Design and Evaluation of a Prospective Payment System for Hospital Based Outpatient Care

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Executive Summary

This report presents the development and modeling of a Prospective Payment System (PPS) for the facility cost of outpatient care. The development of the system was required by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Act called for the design and modeling of a PPS for all hospital outpatient services (e.g., same day surgery units, emergency rooms, outpatient clinics, etc.). The facility cost refers to the hospital cost for providing care (e.g., room charges, medical and surgical supplies, etc.) and excludes the physician's professional service.

During the period 1988-1990, HCFA funded the development of Version 1.0 of the Ambulatory Patient Groups (APGs). The APGs are a patient classification system that was designed to be used as the basis of an outpatient PPS. Version 1.0 of the APGs was released in the spring of 1991. During the period 1991-1994, a number of payors, including state medicaid agencies and Blue Cross and Blue Shield plans, began using APGs for outpatient payment. Individual providers also began using APGs for internal management. The availability of improved data, the expanding use of APGs and the potential use of APGs as the basis of a Medicare outpatient PPS resulted in HCFA funding the development of Version 2.0 of the APGs. In addition, one of the objectives of the development of Version 2.0 was to simplify the APG system so that it could be more easily implemented as the basis of a Medicare outpatient PPS.

The research project to develop Version 2.0 of the APGs was initiated in 1992. The development of Version 2.0 of the APGs was performed in close cooperation with the Health Care Financing Administration (HCFA). Frequent meetings and briefings were held with members of the research, operations and policy staffs at HCFA. Operational and policy implications relating to an outpatient PPS were discussed and evaluated with HCFA staff throughout the development. Version 2.0 of the APGs was completed and released in August of 1995.

The process of formulating Version 2.0 of the APGs was highly iterative, involving statistical results from historical data combined with clinical judgment. The end result is a clinically consistent group of patient classes that are homogeneous in terms of resource use. There are 139 procedure APGs, 83 medical APGs, 58 ancillary service APGs, 2 incidental APGs and 8 error

APGs for a total of 290 APGs. The APGs describe the complete range of services provided in the outpatient setting. The APGs can form the basic building blocks for a visit based outpatient PPS and can provide a flexible structure for configuring the payment system to meet specific policy objectives.

In addition to the development of Version 2.0 of the APGs, the project also evaluated alternative designs for an APG based outpatient PPS using historical Medicare data. The objective was to develop a payment system design that provided the basic structure for an outpatient PPS, but was flexible enough to accommodate a wide range of policy options.

In the APG system, a patient is described by a list of APGs that correspond to each service provided to the patient. The assignment of multiple APGs to a patient is in contrast to the DRGs, which always assign a patient to a single DRG. In the outpatient setting, the diversity of sites of service (i.e., same day surgery units, ERs and outpatient clinics), the wide variation in the reasons patients require outpatient care (e.g., ranging from well care to critical trauma care) and the high percentage of cost associated with ancillary services (i.e., the cost of ancillary services can often exceed the cost of the basic visit) necessitates a patient classification scheme that can reflect the diversity of services rendered to the patients. The APGs address the diversity within the outpatient setting by assigning patients to multiple APGs. In an outpatient PPS, each APG would have a standard payment rate, and the payment for a patient would be computed by summing the payment rates across all the APGs assigned to the patient with the discounting of second and subsequent procedures.

The design of an APG based outpatient PPS has five essential components:

Basis of Payment Weights

The APG payment weights can be computed based on the charges or cost reported by hospitals. Since the markup from cost to charges can vary considerably across hospital outpatient departments, there can be substantial differences in the payment weights computed from charges versus those computed from cost.

Ancillary Packaging

A patient with a significant procedure or a medical visit may have ancillary services performed as part of the visit. Ancillary packaging refers to the inclusion of certain ancillary services into the APG payment rate for a significant procedure or medical visit. For example, a chest x-ray would be packaged into the payment for a pneumonia visit. The extent of ancillary packaging is a policy decision and can vary from none to the full packaging of all low cost, routine ancillary tests and procedures.

Outlier Policy

Outliers are atypical cases that have costs much higher than the APG payment amount. Additional payments can be provided to outlier cases. The extent of outlier payments can vary from none to a significant percentage of cases being provided outlier payments.

Discounting

When multiple significant procedures are performed or when the same ancillary service is performed multiple times, a discounting of the APG payment rates can be applied. Discounting refers to a reduction in the standard payment rate for an APG. Discounting recognizes that the marginal cost of providing a second procedure to a patient during a single visit is less than the cost of providing the procedure by itself. Discounting can be applied to both significant procedures and ancillary services.

Window of Time for Ancillary Packaging

Packaged ancillary services delivered on the day of a significant procedure or medical visit will always be included in the APG payment. The window of time for including packaged ancillaries in the APG payment can be expanded beyond the day of the visit.

The above components of an APG system were configured to produce 13 different formulations of an APG impact simulation model. The 13 different formulations of the APG impact simulation model were evaluated using several statistical measures. The data used in the APG evaluation consisted of 11,412,738 Medicare outpatient claims from the first three months of 1992. In general, the statistical performance of the APGs is better than the statistical performance of the inpatient DRGs. Indeed, for R^2 on trimmed data, which is the most commonly used statistical measure for comparisons, the APGs have an R^2 that is 38.7 percent higher than the DRGs (i.e., 0.660 for APGs versus 0.476 for DRGs).

Medicare payment for hospital outpatient services is based on a complex and confusing collection of payment methods. The current Medicare system pays hospital outpatient services under a number of different methods including fee schedules, blended payment methods and cost based payments. It was beyond the scope of this project to compute actual historical Medicare outpatient payments and compare actual payments to APG based payments. Thus, the results of the 13 APG impact simulations do not precisely reflect the actual impact on hospitals because the actual payments to hospitals based on the current complex and confusing system were not calculated. In addition, for purposes of the impact simulation, APG payment rates were not calculated based on the current level of Medicare program expenditures, which is less than hospital costs, but instead, were calculated based on what total program expenditures would be under a pure cost based system. Thus, for purposes of calculating and comparing the impact of the 13 different APG impact simulations, hospital payments under each specific APG model were computed with the constraint that in the aggregate, Medicare total expenditures under any of the APG models was equal to total hospital costs. The most basic of the 13 formulations of an APG system was selected as the reference APG system and the relative APG impact was computed by comparing cost based APG payments under each of the other APG systems to the reference APG system. The relative APG impact was computed for different categories of hospitals and was used to evaluate each component of the APG system (e.g., the extent of outlier payments) in terms of its relative impact across the different categories of hospitals. In general, the alternative

formulations of an APG system did not result in substantial differences across different categories of hospitals. The only components of the APG system that caused any substantial variations across different categories of hospitals were the selection of charge versus cost based weights and the extent of ancillary packaging.

Based on the evaluation of alternative formulations of the components of the APG system, an APG system with cost based weights, full ancillary packaging, one percent of payments derived from outlier payments, 50 percent multiple significant procedure discounting, no repeat ancillary discounting and a same day window of time for ancillary packaging is recommended.

A visit based APG prospective payment system can provide an effective system for the payment of the facility component of hospital based outpatient care. The APGs form a manageable, clinically meaningful set of patient classes that relate the attributes of patients to the resource demands and associated costs experienced by a hospital outpatient department. The components of the APG payment system can be configured to achieve specific policy objectives and to provide financial incentives for hospitals to provide efficient care. The current Medicare payment system for outpatient services is a complex and confusing collection of payment methods, many of which are based on the cost in the hospital department providing the service. In an era of health care cost containment, a cost based payment system for hospital outpatient care is an anachronism which provides no incentives for the efficient delivery of care and, therefore, must be replaced. An APG based outpatient prospective payment system can be a practical and effective basis for the reform of the Medicare cost based outpatient payment system.

CHAPTER 1

Introduction

Background

Under the Omnibus Budget Reconciliation Act (OBRA) of 1990, Congress directed the Health Care Financing Administration (HCFA) to develop a prospective payment system (PPS) for outpatient care. Section 4151(b)(2) of that act called for the design and modeling of a PPS for hospital outpatient services (e.g., emergency rooms, outpatient clinics, etc.). The outpatient PPS was to include only the facility payment, which refers to the hospital cost for providing care (e.g., room charges, medical and surgical supplies, etc.) and excludes the physician's professional charge. During the period 1988-1990, HCFA funded the development of the Ambulatory Patient Groups (APGs). The APGs are a patient classification system that was designed to be used as the basis of an outpatient PPS. Version 1.0 of the APGs was released in the spring of 1991. Appendix A contains a complete summary of the development of Version 1.0 of the APGs. During the period 1991-1994, a number of payors, including state medicaid agencies and Blue Cross and Blue Shield plans, began using APGs for outpatient payment. In addition, individual providers began using APGs for internal management. The expanding use of APGs and the potential use of APGs as the basis of a Medicare outpatient PPS resulted in HCFA funding the development of Version 2.0 of the APGs. During the period 1992-1995, Version 2.0 of the APGs was developed. The development of Version 2.0 of the APGs had three primary objectives:

1. Review and modify the APG definitions based on data that were more complete and current than the data used in the development of Version 1.0 of the APGs.

2. Review and incorporate suggestions and comments from the users of APG Version 1.0.
3. Simulate and evaluate the payment impact of APG Version 2.0.

The development of Version 2.0 of the APGs was performed in close coordination with the Health Care Financing Administration (HCFA). Frequent meetings and briefings were held with members of the research, operations and policy staffs at HCFA. Operational and policy implications relating to an outpatient PPS were discussed and evaluated with HCFA staff throughout the development. In March of 1995, HCFA submitted a Report to Congress recommending that the APGs, or an APG-like patient classification system, be used as the basis of the Medicare Outpatient PPS. Version 2.0 of the APGs was completed and released in August of 1995. Chapter 4 describes the difference between Versions 1.0 and 2.0 of the APGs.

Overview of APGs

The APGs are a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. A visit represents a contact between the patient and a health care professional. The visit could be for a procedure, for a medical evaluation or simply for an ancillary service such as a chest x-ray.

Patients in each APG have both similar clinical characteristics and similar resource use and cost. Similar resource use means that the resources used are relatively constant across the patients within each APG. However, some variation in resource use will remain among the patients in each APG. In other words, the definition of the APG will not be so specific that every patient is identical, but the level of variation in resource use is known and predictable. Thus, while the precise resource use of a particular patient cannot be predicted by knowing the APG of the patient, the average pattern of resource use of a group of patients in an APG can be accurately predicted. Similar clinical characteristics mean that the patient characteristics included in the definition of the APG should relate to a common organ system or etiology and that a specific medical specialty should typically provide care to the patients in the APG.

APGs were developed to encompass the full range of ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics. APGs, however, do not address phone contacts, home visits, nursing home services or inpatient services. While the anticipated initial application of APGs focuses on Medicare patients, APGs were developed to represent ambulatory patients across the entire patient population. For example, APGs relating to pregnancy were developed even though pregnancy is not usually encountered in the Medicare population.

APGs were developed to differentiate facility costs rather than professional costs. The facility cost refers to the hospital cost for providing care (e.g., room

charges, medical and surgical supplies, etc.) and excludes the physician's professional service.

The data elements used to define APGs were limited to the information routinely collected on the Medicare claim form such as the diagnoses coded in ICD-9-CM and procedures coded in CPT-4. The patient characteristics used in the definition of the APGs were restricted to those available on the Medicare bill in order to insure that the APGs could be readily implemented.

The process of formulating the APGs was highly iterative, involving statistical results from historical data combined with clinical judgment. The end result is a clinically consistent group of patient classes that are homogeneous in terms of resource use.

APGs use procedure as the initial classification variable. All patients who had a significant procedure performed were assigned to APGs based on the significant procedure. A significant procedure is a procedure that is normally scheduled, constitutes the reason for the visit and dominates the time and resources expended during the visit. All medical services provided to the patient are assumed to be an integral part of the significant procedure. Patients with no significant ambulatory procedures who received medical services are assigned to medical APGs. Patients with no significant procedures and no medical services, who only have ancillary services (e.g., a chest x-ray), are described by a list of ancillary APGs corresponding to the ancillary services provided.

The APGs describe the complete range of services provided in the outpatient setting. The APGs can form the foundation for a visit based outpatient PPS since they provide a flexible structure for configuring the payment system to meet specific policy objectives.

In the APG system, a patient is described by a list of APGs that correspond to each service provided to the patient. The assignment of multiple APGs to a patient is in contrast to the Diagnosis Related Groups (DRGs) used to classify inpatients, which always assign a patient to a single DRG. In the outpatient setting, the diversity of sites of service (i.e., same day surgery units, ERs and outpatient clinics), the wide variation in the reasons patients require outpatient care (e.g., ranging from well care to critical trauma care) and the high percentage of cost associated with ancillary services (i.e., the cost of ancillary services can often exceed the cost of the basic visit) necessitates a patient classification system that can reflect the diversity of services rendered to the patient. The APGs address the diversity within the outpatient setting by assigning multiple APGs to patients.

In an outpatient PPS, each APG would have a standard payment rate, and the payment for a patient would be computed by summing the payment rates across all the APGs assigned to the patient. However, in order to provide incentives for cost control and to minimize opportunities for upcoding of APGs, not all the APGs assigned to a patient are used in the computation of the payment. For claims with more than one APG assigned, the APG system

uses two techniques for determining how the APGs assigned to the claim are used to compute the total APG payment for the claim.

Ancillary Packaging

A patient with a significant procedure or a medical visit may have ancillary services performed as part of the visit. Ancillary packaging refers to the inclusion of routine ancillary services into the APG payment rate for a significant procedure or medical visit. For example, a chest x-ray would be packaged into the payment for a pneumonia visit.

Multiple Significant Procedure Discounting

When multiple significant procedures are performed, a discounting of the APG payment rate is applied. Discounting refers to a reduction in the standard payment rate for an APG. Discounting recognizes that the marginal cost of providing a second procedure to a patient during a single visit is less than the cost of providing the procedure by itself.

For example, ancillary packaging and significant procedure discounting would be applicable to a claim for a patient with a fractured finger and a fractured arm who had a cast put on both fractures and had two routine ancillary tests. This claim would be assigned separate APGs for each fracture and each ancillary test. Each of the four APGs assigned to the claim would have a payment amount associated with it. The total APG payment for the claim would be computed as the sum of the APG payment amount for the fractured arm plus a discounted APG payment amount for the fractured finger. There would be no additional payment for the packaged routine ancillary tests since the cost of any packaged ancillaries is included when the APG payment is established for the fractured arm and finger APGs.

In general, a visit based prospective payment system has three components: the patient classification scheme (i.e., APGs), an ancillary packaging process and a payment computation with discounting. The combination of the APGs and the rules for ancillary packaging and discounting constitute the complete APG system.

The structure of the APG system provides considerable flexibility. By modifying the level of ancillary packaging and discounting, the incentives in the system can be altered in order to achieve specific policy objectives. The APG patient classification system provides the basic building blocks that can accommodate a wide range of payment system designs.

CHAPTER 2

Processing of Data Used in Development of APG Version 2.0

Database Used to Develop APG Version 2.0

The HCFA Common Working File (CWF) was used as the analysis database for the development of Version 2.0 of the APGs. The CWF is a comprehensive file of all services rendered to each Medicare beneficiary. An extract from the CWF of all visits to hospital outpatient departments during the first three months of 1992 was obtained. The 1992 data from the CWF contained 14,883,101 claims. The development of Version 1.0 of the APGs utilized a 1988 Medicare data sample containing 1,527,868 claims. There were several data limitations in the 1988 Medicare sample utilized in the development of Version 1.0 of the APGs. These limitations were addressed with the CWF database and are as follows:

Identification of Medical Visits

Based on the claim form from the 1988 Medicare sample, it was not always possible to distinguish a patient who had a medical visit with ancillary services from a patient who had only ancillary services. The 1992 CWF provides a precise identification of medical visit patients.

Missing CPT-4 Codes

When the original 1988 Medicare sample data was collected, hospitals were not required to report the CPT-4 codes associated with all services. For example, the CPT-4 codes associated with psychiatric services, such as group or family therapy, were not required to be reported. In the 1992

CWF, all CPT-4 codes necessary for APG assignment were required to be reported.

Batch Billing

Some claims can contain charges from multiple visits. Claims that encompass multiple visits are referred to as batch bills. Since neither the dates of service nor the number of units of service were collected on the 1988 Medicare sample, it was not possible to identify such claims. For example, if a claim encompassed the services rendered across several days, the claim might represent several separate visits. Without the dates of service available, it was not possible to identify such claims. This was particularly true for therapy claims such as physical therapy. The 1992 CWF database contains the dates of service and the number of units of service.

No Hospital Identifiers

The 1988 Medicare sample did not contain an identification of each hospital in the database. The CWF database includes a hospital identifier that allowed a hospital description file to be linked to the CWF data.

Missing Ancillaries

In general, the 1988 Medicare sample contained only the ancillary services provided during the visit. Ancillary services ordered during the visit and delivered subsequent to the visits, would appear on separate claims. The CWF analysis database allowed the identification of ancillaries provided before and after the visit.

Missing Data Elements

The 1988 Medicare sample did not contain any indication of whether a patient died or was admitted to the hospital. The 1992 CWF allowed the identification of patients who died or were admitted.

In general, the comprehensiveness of the 1992 CWF allowed the thorough review of the APG definitions as well as a more accurate determination of APG relative weights and a more complete simulation of an APG based payment system.

Processing of CWF Data

A total of 14,883,101 hospital outpatient claims from the Common Working File (CWF) for the first quarter of 1992 were obtained from HCFA. The CWF data was converted to a format that facilitated analysis. Figure 2.1 provides an overview of the claims processing logic. The following provides a definition of terminology used to describe the claims processing logic:

Claim

A claim represents a single bill (i.e., a UB-92 claim form) submitted by the provider or beneficiary. A claim can contain services that occurred across multiple encounters or can contain only a subset of the services that occurred during an encounter.

Figure 2.1 Overview of APG Claims Processing Logic

Dates of Service

Each claim contains a specification of the dates of service. The dates of service may indicate that all the services on the claim were provided on a single day or were provided across multiple days.

Visit

A visit is the collection of services that result from an encounter between a health professional and a patient. For the purposes of the initial APG analysis, a visit was defined as all services that are rendered to the same patient, on the same day, by the same provider and are associated with the same reason for the visit. It was necessary to collapse multiple claims to reflect a visit. Given that there is no direct relationship between a claim and visit, there were ambiguities in the process of sorting claims into visits. Thus, the claims processing logic identifies ambiguities relating to the creation of visits from claims.

Revenue Trailer

A revenue trailer refers to a group of four variables on a claim that describe each of the services rendered. The four variables are the HCPCS code, the revenue center code, the number of units and the charge. A claim may contain one or more revenue trailers.

There are four general conditions that describe the claims associated with a specific patient:

Single Claims with Dates of Service that Span More Than One Day

All single claims with dates of service that span more than one day were considered ambiguous and were excluded from the analysis database. Since the units field was found to be unreliable, it was not possible to separate claims that span more than one day into separate visits. This exclusion has a disproportionate impact on claims for therapies such as physical therapy, since they are often batch billed.

Multiple Claims with Overlapping Service Date Ranges

If a patient had a claim with service dates that spanned more than one day and there also existed other claims for that same patient with service dates that overlapped the claim with service dates that spanned more than one day, then all of the claims with overlapping service dates were considered ambiguous in terms of the ability to identify unique visits and these claims were excluded from the analysis database. For example, if there were two claims for a patient, one with dates of service from January 1 to January 5 and the second claim with a date of service of January 3, both claims would be eliminated from the analysis database.

Multiple Claims for Same Patient, Same Provider on the Same Day

If there were multiple medical and/or significant procedure claims for the same patient, for the same provider on the same day, and there were also ancillary service only claims for that patient for that provider on the same day, then it was ambiguous in terms of which medical or significant

procedure claim to associate with the ancillary only claim, and these claims were excluded from the analysis database. Appendix B contains a description of the APG Collapsing Algorithm used to identify ambiguities with these types of claims. All claims for the same patient, same provider on the same day that did not have multiple medical and/or significant procedure claims were collapsed together and included in the final analysis database if they passed the claims editing logic.

Single Claim with Single Date of Service

All single claims with a single date of service with no other claims for the patient on the day of service were included in the final analysis database if they passed the claims editing logic.

The objective of the claims processing logic was to create an analysis database that contained only claims that represented all the services associated with a single visit.

Assignment of Version 1.0 APGs to the 1992 Analysis Database

Version 1.0 of the APGs was defined using 1989 HCPCS procedure codes and 1990 ICD-9-CM diagnosis codes. Since the analysis database was from 1992, the 1992 HCPCS and ICD-9-CM codes were mapped to the corresponding 1989 HCPCS code or 1990 ICD-9-CM code in order to assign the Version 1.0 APGs. While in 1992 hospitals were required to report the HCPCS codes relevant to APG assignment, portions of this requirement were implemented beginning in 1992. Therefore, in order to insure that all applicable APGs were assigned to a claim, the revenue center code was also used to assign certain APGs. Any revenue trailer that did not have a HCPCS code present, but did have a revenue center that could be directly associated with an APG, was assigned an APG based on the revenue center. The list of revenue centers that are directly associated with an APG are contained in Appendix C. The use of revenue centers to assign an APG was necessary for the analysis of the historical Medicare database, but is not intended to be part of an operational APG PPS.

Identifying Medical Visits

HCFA requires outpatient departments to code an evaluation and management CPT-4 code on an outpatient claim in order to indicate that the patient was medically evaluated or treated. The presence of an evaluation and management code is used to distinguish a claim for a medical visit from a claim for only an ancillary service (e.g., a visit for only a chest x-ray). Since the requirement to report the evaluation and management CPT-4 codes was new when the CWF data was collected, the list of CPT-4 codes indicating a medical visit was expanded and the presence of specific revenue centers was also used to indicate a medical visit. The list of CPT-4 codes and revenue

centers used to identify a medical visit is contained in Appendix D. The presence on a claim of any of the CPT-4 codes or revenue centers in Appendix D is referred to as the presence of a medical visit indicator.

Claim Editing

The initial step in the claims processing was to collapse together into a single claim all claims for the same patient, for the same provider, on the same day that met the criteria specified in the APG collapsing algorithm in Appendix B. The collapsing of claims reduced the database from 14,883,101 claims to 14,513,354 claims. The 14,513,354 claims were then evaluated for ambiguities in the identification of the claim as representing a single visit and data edited for the presence of errors. A detailed discussion of the edits is contained in Appendix E. The results of the editing are summarized in Figure 2.1. There are seven types of edits:

Revenue Center Edits

Medicare patient charges are reported using the UB-92 claim form. The charge portion of the UB-92 consists of four data items: the HCPCS code, the number of units, the revenue center code and the charge. These four data items are referred to as a revenue trailer. The revenue center codes were developed by HCFA and indicate the precise nature of the charge (e.g., pharmacy). On a UB-92 claim there will typically be a series of such revenue trailers used to describe the services rendered to a patient. Each revenue trailer should minimally contain the revenue center code and the charge amount. The HCPCS code and the number of units may not always be present on the revenue trailers. The HCPCS code is not always present because some services can not be described by a HCPCS code (e.g., room charges). For revenue trailers that do not have an APG assigned, the value of the revenue center code is used to edit the claim. The following edits are associated with revenue centers:

Error

The occurrence of the revenue center was an error and the claim was excluded from the analysis. The revenue centers that are considered errors are primarily revenue centers associated with inpatient care or other settings such as home health services (e.g., revenue center 201, ICU surgical). In addition, if there was no revenue center code or an invalid revenue center code in a revenue trailer that had no APG assigned, the claim was also excluded from the analysis.

Require CPT-4 Code

When these revenue centers occur without a valid CPT-4 code in the revenue trailer, the claim was considered in error and was excluded from the analysis database (e.g., revenue center 300, general laboratory). These revenue centers indicate a service was performed that should have a CPT-4 code present to precisely describe the service.

Error Type	Count	Percent	Error
Revenue Center	20,152	0.139	Blank or invalid revenue center
	3,477	0.024	Revenue center considered an error
	272,797	1.880	CPT-4 code required for the revenue center
	25,185	0.174	Revenue center requires a significant procedure
HCPCS Codes	55,663	0.384	Invalid CPT-4 or HCPCS code
	400	0.003	HCPCS code indicating a noncovered procedure
	9,699	0.067	Not permitted HCPCS code
	19,281	0.133	Inpatient procedures present
	4,619	0.032	Nonapplicable care settings and services
ICD-9-CM Codes	3,922	0.027	Invalid ICD-9-CM code
	9	0.000	E-code as reason for visit
	411	0.003	ICD-9-CM code requires procedure
Age, Sex	86	0.001	Invalid age or age conflict
	1,145	0.008	Invalid sex or sex conflict
Charge or Cost	5,141	0.035	Fully allocated direct charges equal to zero
	10	0.000	Total charge differs significantly from sum of revenue trailer charges
	426,418	2.938	Missing or invalid cost-to-charge ratio for provider
Claims Problems	534,419	3.682	Possible duplicate claim
	372,617	2.567	Claim for professional services
	141,998	0.978	Excluded provider
	0	0.000	Invalid dates of service
	197,318	1.360	HCFA claims editing logic
	262,230	1.807	No significant procedure, no ancillary, no medical visit indicator
Ambiguous	1,526,133	10.515	Claim could not be separated into visits
APG Logic	43,182	0.298	Ancillary only claims with incidental services
	794	0.006	Medical visit indicator present, no medical APG
Totals	3,927,106	–	Total number of errors
	3,093,074	21.312	Total number of claims eliminated from analysis

Table 2.1 Results of Data Editing

Require Significant Procedure

If these revenue centers occur and there is no significant procedure present on the claim, the claim was considered an error and excluded from the analysis (e.g., revenue center 360, operating room services).

All actions associated with revenue centers are summarized in Appendix F.

HCPCS Code Edits

Invalid HCPCS and CPT-4 codes were identified as errors. In addition, CPT-4 codes representing a noncovered procedure, CPT-4 codes that are not allowed to be reported by HCFA, CPT-4 codes representing inpatient procedures and CPT-4 codes referring to nonapplicable care settings (e.g., nursing homes) or services (e.g., autopsy) were considered errors.

ICD-9-CM Code Edits

Invalid ICD-9-CM diagnosis codes were identified as errors. In addition, an E-code as a reason for visit and ICD-9-CM codes that require a procedure (e.g., delivery) that did not have a procedure present on the claim were considered errors.

Age and Sex Edits

Invalid Age or sex values were identified as errors. In addition, conflicts between age and diagnosis, sex and diagnosis and sex and procedure (e.g., male D&C) were considered errors.

Charge or Cost Edits

If the fully allocated direct charges or cost (see chapter 3 for a definition of fully allocated charges or cost) were zero, the claim was considered an error. If the sum of the charges or costs on the individual revenue trailer did not equal, within rounding error, the total charges or cost reported on the claim, the claim was an error. If there were no cost-to-charge ratios available to convert the provider's charges to cost, all the claims for the provider were considered an error.

Claims Edits

If there were duplicate claims present, all but one of the duplicate claims was considered an error. If the claim was for professional services, it was considered an error. A list of providers whose cost information was considered unreliable was provided by HCFA. These providers included Indian Health Service hospitals and other all inclusive rate hospitals that were paid a flat rate for all outpatient services. All claims associated with these providers were considered errors. If the dates of service on the claim were invalid, the claim was considered an error. HCFA provided additional claims editing logic, which addressed relations among claim types, revenue centers and HCPCS codes as well as reporting requirements. For example, if the revenue center indicated that the type of drug administered should be specified (i.e., revenue center 636), then the claim was considered an error unless the HCPCS code for the drug was present on the claim. Any claims failing the HCFA claims editing logic

were considered errors. Any claims which could not be unambiguously identified as a single visit were also considered errors.

APG Logic Edits

If there was no significant procedure, no medical visit indicator and no ancillary APG present on the claim, the claim was considered an error. If there were any incidental services normally associated with a significant procedure or medical visit present on an ancillary only claim, the claim was considered to be an error. If a medical visit indicator was present but a medical APG could not be assigned, the claim was considered an error.

The edits were quite stringent, and if there was any ambiguity the claim was excluded from the analysis. There were 3,927,106 errors detected. Only one occurrence on a claim of any specific error was counted. Thus, if there were two invalid HCPCS codes on one claim, they were counted as one error. Errors occurred on 3,093,074 different claims. Thus, 21.31 percent of the claims were eliminated from the analysis. More than half of the claims that were eliminated from the analysis (1,526,133) were eliminated because the claim could not be unambiguously identified as representing a single visit.

The edits in Table 2.1 identified errors in the data but did not evaluate the reasonableness of the charge or cost information. In addition to the edits in Table 2.1, the following edits were performed on the charge and cost information. Any claim that failed any of these edits was eliminated from the analysis database.

- Revenue trailer with an ancillary APG assigned that has a charge or cost equal to zero.
- Revenue trailer with an ancillary APG assigned that has a charge greater than $10,000.
- Direct charge or cost for a significant procedure or medical visit less than one dollar.
- Revenue trailer with an ancillary APG assigned that has a charge that is greater than five standard deviations above the mean of the log of charges for the ancillary APG.

While these edits only eliminated 7,542 claims from the analysis database, the claims eliminated had extreme charges or cost values, which clearly represented errors. For example, one of the claims eliminated had a revenue trailer assigned to the ancillary APG 351 (multichannel chemistry tests) that had a charge of $1,020,528.40. Thus, after eliminating claims with errors and claims with unreasonable charges or cost values, there were 11,412,738 claims in the analysis database.

Converting Charges to Cost

Based on the provider number, each claim was linked to a file provided by HCFA that contained departmental cost-to-charge ratios for each hospital. There were 63 separate hospital departments defined in the hospital

description file. Hospitals would not necessarily have a cost-to-charge ratio for every department. Each revenue center code was either mapped to one of 63 departments or was designated as excluded. Revenue trailers with a revenue center code mapped to excluded were ignored in the determination of the cost. Some revenue center codes were mapped to more than one department. When this occurred, the departments associated with the revenue center code were ordered in a hierarchical list. The complete mapping of revenue center codes to departments is contained in Appendix G. The charges on a claim were converted to cost by using the departmental cost-to-charge ratios. If there were no cost-to-charge ratios available for a hospital, the claims from that hospital were eliminated from the analysis. If a cost-to-charge ratio was missing for only a subset of departments in a hospital, then the overall hospital cost-to-charge ratio was used for those departments. If a revenue center was mapped to more than one department, then the first nonzero cost-to-charge ratio in the hierarchical list of departments was used to convert the charges to cost. In general, the cost-to-charge ratios for ancillary departments tended to be lower than for other hospital departments. For example, the average cost-to-charge ratio for diagnostic radiology, laboratory and electrocardiology were 0.66, 0.54 and 0.39, respectively. In comparison, the average cost-to-charge ratio for clinics, emergency room and operating room were 1.30, 1.06 and 0.77, respectively.

Interventional Radiology Logic

In 1992, the CPT-4 codes associated with interventional radiology were modified. Prior to 1992, the complete interventional radiology procedure was reported with a single code. Beginning in 1992, interventional radiology procedures were reported with multiple codes. For example, any injection associated with the interventional radiology procedure was reported as a separate code. In order to avoid having multiple APGs assigned to codes representing the same interventional radiology procedure, interventional radiology logic was developed. The interventional radiology logic is contained in Appendix H. The interventional radiology logic was only used to process the 1992 claims data and is not included in Version 2.0 of the APGs.

CHAPTER 3

Development of APG Analysis Reports

Determining the Direct Charges and Cost for an APG

Each claim in the analysis database contains a series of revenue trailers. Each revenue trailer has an associated charge amount and cost amount. The charges and cost were aggregated into one of three categories:

- Direct
- Packaged ancillaries
- Nonpackaged ancillaries

The direct charges and cost represent all the charges and cost associated with the visit, exclusive of ancillary services (e.g., room, pharmacy, medical surgical supplies, etc.).

Based on the combination of APGs that occur on the claim, each claim was assigned to one of three different types:

- Patients with a significant procedure
- Patients with no significant procedure, but with a medical visit
- Patients with neither a significant procedure nor a medical visit who received ancillary services only

A claim could have multiple APGs assigned (e.g., a significant procedure APG plus two ancillary APGs). The significant procedure APG (ignoring, for the moment, the situation of multiple significant procedure APGs) and the medical APG are referred to as the primary APG. Patients are assigned to either a significant procedure or a medical APG, but can never have both a significant procedure and a medical APG. In order to compute the direct

charges or cost for the primary medical or significant procedure APG, each revenue trailer had to be evaluated to determine if the charges or cost for that revenue trailer should be included in the direct charges or cost for the APG (e.g., nonpackaged ancillaries should not have their charges or cost included in the computation of the direct charges or cost for a primary medical or significant procedure APG). If the revenue trailer had an APG assigned, then the APG was used to determine if the charges or cost for the revenue trailer should be included in the direct charges or cost of the primary APG. If there was no APG assigned to the revenue trailer, then the revenue center had to be used to determine whether the charges or cost for the revenue trailer should be included in the direct charges or cost of the primary APG.

The direct charges or cost for a significant procedure APG could only be calculated using claims that had a single significant procedure APG. Patients with more than one significant procedure could not have the direct charges or cost computed because the direct charges or cost of performing each procedure would be shared across the procedures. The process of determining the direct charges or cost for a primary significant procedure APG is summarized in Figure 3.1.

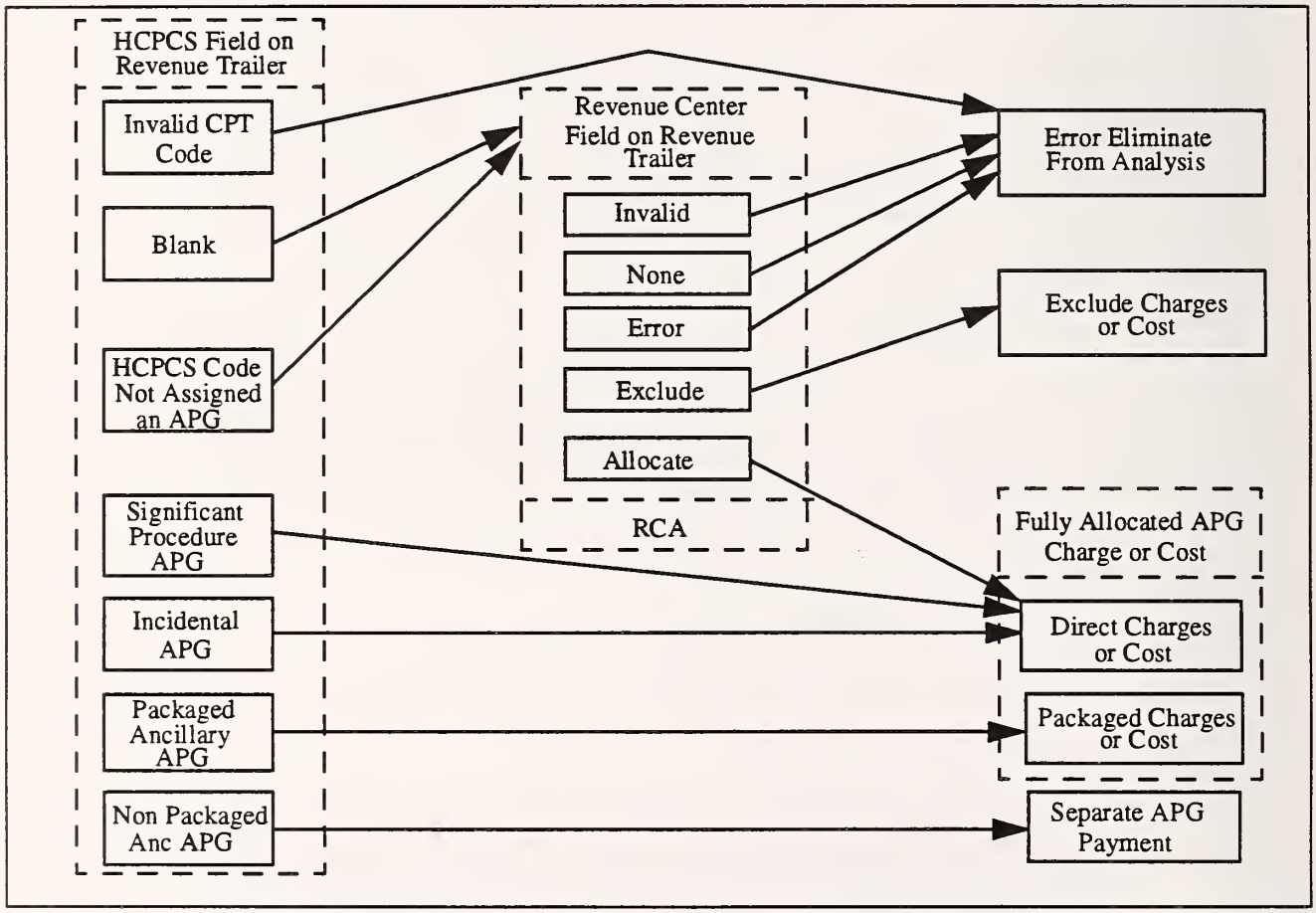

Figure 3.1 Determination of the Direct Charges or Cost for Claims with Only One Significant Procedure

As shown in Figure 3.1, the total charges or cost associated with the primary significant procedure APG is comprised of the direct charges or cost plus the charges or cost associated with packaged ancillaries. If an APG had been assigned to a revenue trailer, then, as shown in Table 3.1, the APG was used to determine if the charges or cost for the revenue trailer should be associated with the primary significant procedure APG charges or cost.

Type of APG on Revenue Trailer	Charge or Cost Included in Primary APG
Primary significant procedure APG	Yes
Packaged ancillary APGs	Yes
Nonpackaged ancillary APGs	No
Incidental procedure APGs	Yes

Table 3.1 Inclusion of Charges or Cost in Primary APG by Type of APG

The Revenue Center Allocation (RCA) is a summary of the uses of the revenue center field in the APG processing. As previously discussed, the revenue center was used to assign an APG (see Appendix C) and edit claims (see Appendix E). In addition, for revenue trailers with no APG assigned, the revenue center was used to determine which revenue trailers should have their charges or cost included in the direct charges for the primary APG. The complete RCA is contained in Appendix F. Relative to the inclusion of charges or cost in the direct charges or cost for a primary APG, there are three different types of actions which could be taken, depending on the value of the revenue center code.

Exclude

The charges associated with this revenue center were excluded from the analysis (e.g., revenue center 998, beauty shop/barber). Only the revenue trailer containing this revenue center was excluded; the rest of the claim was used in the analysis.

Allocate

The charge associated with this revenue center was included in the direct charges or cost of the primary APG (e.g., revenue center 251, generic drugs).

Allocate SP Only

The charges or cost associated with this revenue center were included in the direct charges or cost of a primary significant procedure APG (e.g., revenue center 360, operating room services).

The resulting direct charges or cost of the primary significant procedure APG include the charges or cost for all revenue centers associated with the procedure. The fully allocated significant procedure charges or cost for an APG include the direct charges or cost as well as all packaged ancillaries.

The determination of the fully allocated primary medical APG charges or cost was similar to the computation for the fully allocated primary significant procedure charges or cost. The major difference was that, since the medical APG was assigned based on the ICD-9-CM diagnosis codes, there were no charges or cost associated directly with the medical APG. The ICD-9-CM diagnosis codes are not part of the revenue trailer portion of the UB-92 and, therefore, do not have associated charges or cost or a revenue center. Thus, the fully allocated charges or cost for a medical visit were derived from the revenue centers (e.g., room charges) that represent the services that comprise the medical visit plus the packaged ancillary and incidental procedure charge or cost. The RCA was also used to identify the revenue centers that are included in the direct charges or cost associated with a medical APG. Since only one medical APG can be assigned to a patient, multiple medical APGs are not possible. The process of determining the fully allocated charges or cost for a primary medical APG is summarized in Figure 3.2

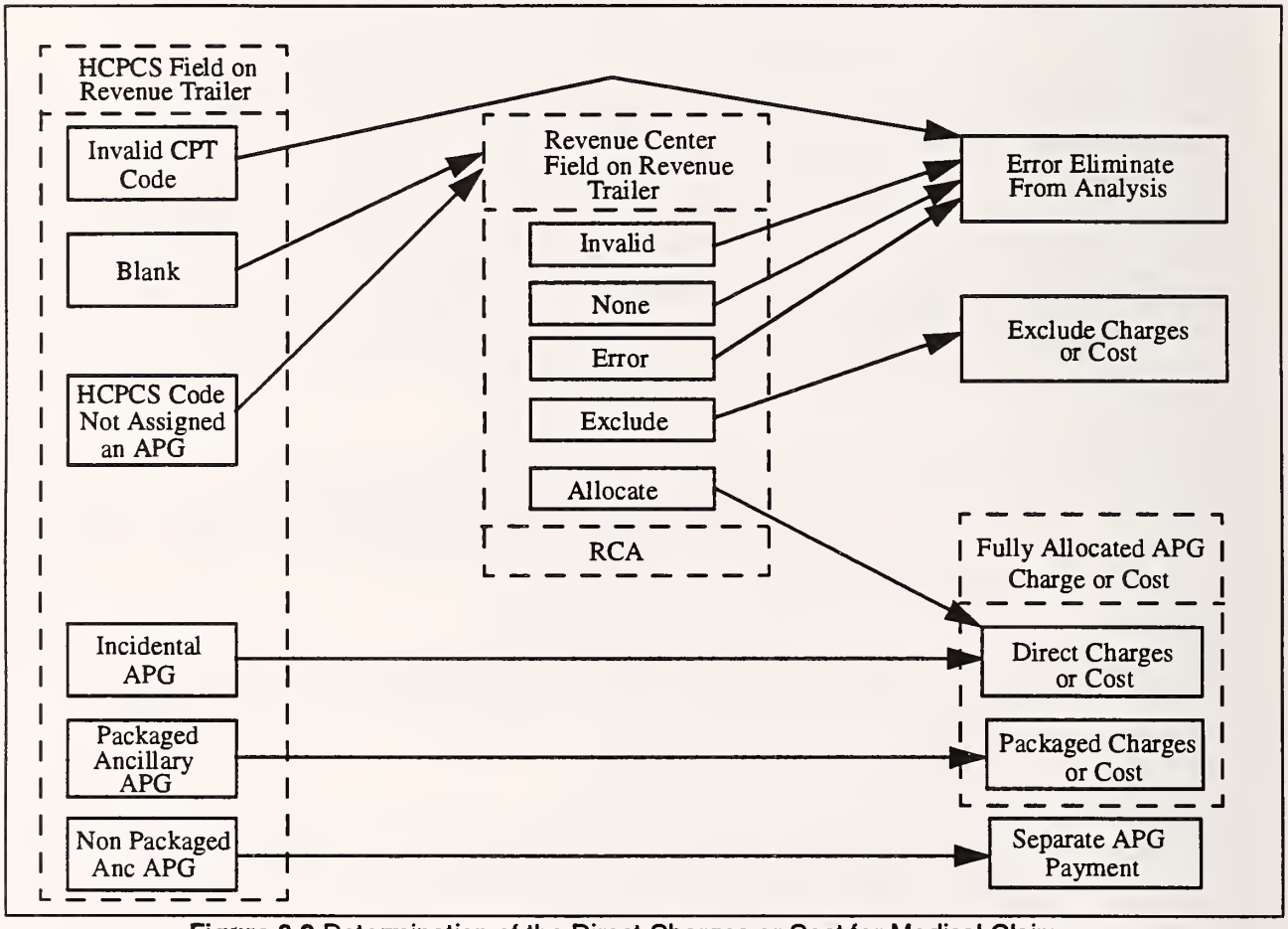

Figure 3.2 Determination of the Direct Charges or Cost for Medical Claims

In the computation of the fully allocated significant procedure and medical APG charges or cost, it was necessary to sum across all the different revenue trailers to obtain the fully allocated charges or cost. However, for the ancillary APGs it was assumed that the full charges or cost were present in the revenue

trailer that contains the CPT-4 code associated with the ancillary APG. In the RCA, if there were any ancillary revenue centers that were not on a revenue trailer containing the ancillary CPT-4 code, then the revenue trailer would be given the "requires CPT-4 code" designation and the claim would have been excluded from the analysis database.

APG Analysis Reports

Once the fully allocated charges or cost were computed for each claim, a set of reports was produced for each APG. There are two types of reports, one for significant procedure and medical APGs and the other for ancillary APGs.

Significant Procedure and Medical APG Charges or Cost Reports

For each significant procedure and medical APG, a three section report was produced. The first section is an overview of the charge or cost components for each of the procedures or diagnoses that make up the APG. Procedures or diagnoses were sorted based on the number of claims with each HCPCS procedure code or ICD-9-CM diagnosis code. A sequence number was assigned based on this sort, and the procedures or diagnoses are presented in sequence number order (from low to high). The second section of the report is a more detailed breakout of the charges or cost by ancillary service area. The second section of the report is also in sequence number order. The third section of the report is simply a description of each procedure or diagnosis in the APG. Unlike the first two sections of the report, this section is sorted in code order and cross referenced to the sequence number.

An example of the first section of the report is shown in Table 3.2. The report was produced separately for charges and cost. The report for cost contains the following columns from left to right:

1. **Seq** is the sequence number. It was assigned from low to high based on the number of claims for the procedure or diagnosis.
2. **Code** is the significant procedure CPT-4 code or ICD-9-CM diagnosis code used to assign the APG.
3. **Count** is the number of claims with the code.
4. **% PAT APG** is the percent of total claims in the APG with the specified procedure or diagnosis code.
5. **DIR AVG COST** is the average direct cost.
6. **DIR CV COST** is the coefficient of variation of direct cost.
7. **PKG AVG COST** is the average cost of packaged ancillaries.
8. **TOT AVG COST** is the average fully allocated cost which is the sum of DIR AVG COST and PKG AVG COST.
9. **% OF TOT COST** is the percent of total cost which is the percent of the total fully allocated cost in the APG with the specified significant procedure or diagnosis code.

10. **TOT MEDIAN COST** is the median value of the total fully allocated cost.
11. **TOT CV COST** is the coefficient of variation of the total fully allocated cost.
12. **% $PK ANC COST** is the percent of TOT AVG COST that comes from packaged ancillaries.
13. **% PAT ER** is the percent of claims that have an emergency room revenue center code present.

The second section of the report is a more detailed breakout of the packaged ancillaries and direct costs. The first four fields replicate the first four fields of the preceding report. A report for cost is shown in Table 3.3 and includes the following columns from left to right:

1. **Seq** is the sequence number. It was assigned from low to high based on the number of claims for procedure or diagnosis.
2. **Code** is the significant procedure CPT-4 code or ICD-9-CM diagnosis code used to assign the APG.
3. **Count** is the number of claims with the code.
4. **% PAT APG** is the percent of total claims in the APG with the specified procedure or diagnosis code.
5. **% PAT PKG ANC** is the percent of claims with packaged ancillaries.
6. **PKG AVG** is the average packaged cost per case.
7. **RAD% PAT** is the percent of claims with packaged radiology cost.
8. **RAD AVG** is the average packaged radiology cost.
9. **LAB% PAT** is the percent of claims with packaged laboratory cost.
10. **LAB AVG** is the average packaged laboratory cost.
11. **EKG% PAT** is the percent of claims with packaged EKG cost.
12. **EKG AVG** is the average packaged EKG cost.
13. **ANS% PAT** is the percent of claims with packaged anesthesia cost.
14. **ANS AVG** is the average packaged anesthesia cost.
15. **PATH% PAT** is the percent of claims with packaged pathology cost.
16. **PATH AVG** is the average packaged pathology cost.
17. **DIR AVG** is the average direct cost.
18. **MSS% PAT** is the percent of claims with an allocated medical surgical supply costs.
19. **MSS AVG** is the average medical surgical supply cost.
20. **PHM% PAT** is the percent of claims with allocated pharmacy cost.
21. **PHM AVG** is the average pharmacy cost.

Seq	Code	Count	% PAT APG	DIR AVG COST	DIR CV COST	PKG AVG COST	TOT AVG COST	% OF TOT COST	TOT MEDIAN COST	TOT CV COST	% $ PK ANC COST	% PAT ER
1	28297	4	0.18	1548	0.27	276	1824	0.25	1755	0.28	15.14	0.00
2	28294	15	0.68	1094	0.49	254	1347	0.68	1186	0.47	18.82	0.00
3	28298	54	2.43	1121	0.37	140	1261	2.30	1198	0.37	11.10	0.00
4	28110	58	2.61	879	0.44	158	1037	2.03	993	0.47	15.27	3.45
5	28299	97	4.37	1123	0.46	133	1256	4.11	1117	0.46	10.58	0.00
6	28293	147	6.62	1439	0.46	163	1602	7.95	1507	0.45	10.17	1.36
7	28290	472	21.27	1117	0.56	145	1262	20.10	1134	0.54	11.49	1.27
8	28296	552	24.88	1177	0.50	156	1332	24.82	1206	0.49	11.68	1.99
9	28292	820	36.95	1205	0.51	160	1364	37.76	1272	0.49	11.70	1.10
	Total	2219	100.00	1180	0.51	155	1335	100.00	1209	0.50	11.60	1.35

Table 3.2 APG Cost Analysis Report for Significant Procedure APG 32 (Bunion Procedures)

				PACKAGED ANCILLARIES												DIRECT COSTS				
Seq	Code	Count	% PAT APG	% PAT PKGANC	PKG AVG	RAD% PAT	RAD AVG	LAB% PAT	LAB AVG	EKG% PAT	EKG AVG	ANS% PAT	ANS AVG	PATH% PAT	PATH AVG	DIR AVG	MSS% PAT	MSS AVG	PHM% PAT	PHM AVG
1	28297	4	0.18	100.00	276	75.00	61	25.00	15	25.00	5	100.00	189	50.00	6	1548	100.00	130	100.00	101
2	28294	15	0.68	93.33	254	60.00	53	53.33	48	33.33	5	73.33	133	66.67	13	1094	100.00	270	100.00	58
3	28298	54	2.43	100.00	140	51.85	35	51.85	28	35.19	8	77.78	57	57.41	12	1121	90.74	253	98.15	44
4	28110	58	2.61	96.55	158	39.66	27	48.28	31	22.41	5	75.86	73	60.34	20	879	96.55	174	94.83	46
5	28299	97	4.37	94.85	133	46.39	33	53.61	24	29.90	7	59.79	51	69.07	17	1123	87.63	252	85.57	44
6	28293	147	6.62	97.28	163	58.50	42	57.82	24	40.14	9	65.31	68	59.18	18	1439	90.48	423	87.07	60
7	28290	472	21.27	91.53	145	43.22	31	54.03	24	36.02	8	60.59	65	60.81	16	1117	90,68	208	87.50	45
8	28296	552	24.88	94.20	156	49.64	35	55.98	23	36.96	8	67.75	75	56.16	14	1177	90.94	232	90.04	49
9	28292	820	36.95	95.12	160	48.66	37	51.95	24	33.41	8	66.59	73	62.80	17	1205	90.12	209	86.34	44
	Total	2219	100.00	94.41	155	48.26	35	53.72	24	34.88	8	65.84	71	60.57	16	1180	90.63	231	88.15	47

Table 3.3 APG Cost Analysis Report with Detailed Breakout of Costs for Significant Procedure APG 32 (Bunion Procedures)

The third section of this report is a table of descriptions for each procedure or diagnosis code. Unlike the preceding two tables, which were ordered by the number of claims (count), this table is in code order. Each code has a sequence number to allow cross referencing to the first two reports. A report for procedures is shown in Table 3.4 and includes the following fields from left to right:

1. **Seq** is the sequence number from the preceding tables. It links the descriptions to the other reports.
2. **Code** is the CPT-4 procedure code or ICD-9-CM diagnosis code.
3. **Years** are the years for which this code was valid.
4. **Description** of the code.

Seq	Code	Years	Description (CPT-4 Copyright American Medical Association)
4	28110	89-95	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
7	28290	89-95	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy
9	28292	89-95	Hallux valgus (bunion) correction, with or without sesamoidectomy; Keller, McBride or Mayo type procedure
6	28293	89-95	Hallux valgus (bunion) correction, with or without sesamoidectomy; resection of joint with implant
2	28294	89-95	Hallux valgus (bunion) correction, with or without sesamoidectomy; with tendon transplants
8	28296	89-95	Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotmy
1	28297	89-95	Hallux valgus (bunion) correction, with or without sesamoidectomy; lapidus type procedure
3	28298	89-95	Hallux valgus (bunion) correction, with or without sesamoidectomy; by phalanx osteotomy
5	28299	89-95	Hallux valgus (bunion) correction, with or without sesamoideactomy; by other methods

Table 3.4 APG Analysis Report with Code Descriptions for Significant Procedure APG 32 (Bunion Procedures)

Ancillary APG Charges or Cost Report

For each ancillary APG, a two section report was produced. The first section shows the charge, or cost data for each CPT-4 code that comprises the APG, and the second section is a description of the ancillary procedure codes in the APG. Reports were produced separately for cost and charges.

The first section of the report is organized by the individual CPT-4 codes that comprise the APG. A sequence number was assigned to each CPT-4 code (from low to high). A report for cost is shown in Table 3.5 and includes the following columns:

1. **Seq** is the sequence number. It was assigned from low to high based on the number of revenue trailers with the procedure code.

2. **Code** is the CPT-4 code used to assign the APG.
3. **Count** is the number of revenue trailers that contained the code.
4. **% APG** is the percent of total revenue trailers in the APG with the specified ancillary procedure code.
5. **% CODE** is the percentage of all revenue trailers with the specified code that passed all the edits and were included in the report.
6. **AVG COST** is the average cost of revenue trailers with the code.
7. **MEDIAN COST** is the median cost of revenue trailers with the code.
8. **CV COST** is the coefficient of variation of cost for revenue trailers with the code.

The second section of the report is a table of descriptions. As in the case of the significant procedure and diagnosis APG reports, this report is in code order rather than sequence order. The sequence number was included to facilitate cross referencing. A report is shown in Table 3.6 and includes the following columns from left to right:

1. **Seq** is the sequence number from the preceding table. It links the descriptions to the other reports.
2. **Code** is the ancillary procedure CPT-4 code.
3. **Years** is the years for which this code was valid.
4. **Description** of the code.

Seq	Code	Count	% APG	% CODE	AVG COST	MEDIAN COST	CV COST
1	80011	13445	0.53	95.46	29	19	1.01
2	80009	28410	1.12	97.07	29	20	0.92
3	80010	29174	1.15	96.75	25	18	1.00
4	80005	54023	2.14	96.02	22	18	0.81
5	80008	60979	2.41	95.79	26	20	0.86
6	80003	94747	3.75	92.59	21	19	0.70
7	80012	112047	4.43	97.76	19	16	0.78
8	80002	142660	5.64	84.64	10	7	0.97
9	80016	179681	7.10	97.44	22	18	0.78
10	80006	194847	7.70	96.84	21	18	0.80
11	80018	232362	9.19	98.66	24	21	0.75
12	80004	254233	10.05	96.31	19	17	0.72
13	80007	337848	13.36	97.62	23	19	0.76
14	80019	697465	27.57	96.94	23	17	0.79
	Total	2431921	96.14	96.14	22	17	0.81

Table 3.5 APG Cost Analysis Report for Ancillary APG 351 (Multichannel Chemistry Tests)

Seq	Code	Years	Description (CPT-4 Copyright American Medical Association)
8	80002	89-94	Automated multichannel test, 1 or 2 clinical chemistry test(s)
6	80003	89-94	Automated multichannel test, 3 clinical chemistry tests
12	80004	89-94	Automated multichannel test, 4 clinical chemistry tests
4	80005	89-94	Automated multichannel test, 5 clinical chemistry tests
10	80006	89-94	Automated multichannel test, 6 clinical chemistry tests
13	80007	89-94	Automated multichannel test, 7 clinical chemistry tests
5	80008	89-94	Automated multichannel test, 8 clinical chemistry tests
2	80009	89-94	Automated multichannel test, 9 clinical chemistry tests
3	80010	89-94	Automated multichannel test, 10 clinical chemistry tests
1	80011	89-94	Automated multichannel test, 11 clinical chemistry tests
7	80012	89-94	Automated multichannel test, 12 clinical chemistry tests
9	80016	89-94	Automated multichannel test, 13-16 clinical chemistry tests
11	80018	89-94	Automated multichannel test, 17-18 clinical chemistry tests
14	80019	89-94	Automated multichannel test, 19 or more clinical chemistry tests

Table 3.6 APG Analysis Report with Code Descriptions for Ancillary APG 351 (Multichannel Chemistry Tests)

In 1993, portions of the CPT-4 codes relating to laboratory were extensively modified. In order to evaluate the new codes, 1993 summary charge data by CPT-4 code was obtained from HCFA. For each laboratory CPT-4 code the summary data included the count, median charge and coefficient of variation of charges. The 1993 laboratory data was organized by APG and used to formulate the APG Version 2.0 laboratory APGs. Although the 1993 laboratory data was used to formulate the APG Version 2.0 laboratory APGs, this data was not used in any of the APG impact simulation analysis.

These reports comprise the basic information that was used to create Version 2.0 of the APGs. The reports were initially created using Version 1.0 of the APGs. As modifications were made to the APG definitions, these reports were reproduced using the modified APG definitions.

CHAPTER 4

Development of APG Version 2.0

APG Modification Process

Once the APG analysis reports were developed based on Version 1.0 of the APGs, they were used as the basis for a complete reevaluation of the Version 1.0 APG definitions. The decision to make any APG modifications was based on a combination of clinical judgement and the results from the review of the APG analysis reports that were created using the CWF data. Decisions on specific modifications were made in the following manner.

- Project medical staff, in conjunction with HCFA staff, made an initial assessment of the clinical meaningfulness of any potential APG modification. Potential APG modifications that are clinically unreasonable often occur when reviewing statistical data on the average charges or cost of individual CPT-4 procedure or ICD-9-CM diagnosis codes. An individual code with a relatively low frequency of occurrence can sometimes appear to be in the wrong APG based on historical data. Statistical results that had no clinical rationale were not used as the basis of APG modifications. In general, potential APG modifications that were clinically unreasonable were not given further consideration. However, if the procedure or diagnosis in question occurred with a high frequency, additional confirmation was obtained from experts in the specialty area.
- If, in the judgement of the project medical staff and HCFA staff, there was any possible clinical merit to a potential APG modification, then the modification was reviewed with either the internal clinical consultants or outside experts in the specialty area of the modification. A wide cross section of outside experts were consulted during the development of Version 2.0 of the APGs. The list of outside expert consultants is

contained in Appendix I. The purpose of the review was to provide additional clinical confirmation for APG modifications. While this was not a formal consensus panel process, every attempt was made to have all APG modifications clinically confirmed by outside experts.

- Any supporting data for the APG modifications was also reviewed. The supporting data that was evaluated included the historical cost or charges, relative values if available, the amount and type of packaged ancillaries, the overall frequency of occurrences and the frequency of treatment in the emergency room. The coding implications of any APG modification were also taken into consideration.
- All APG modifications were developed in close collaboration with HCFA staff. Frequent meetings and briefings were held with members of the research, operations, coding and policy staffs at HCFA. Operational and policy implications of any APG modifications were discussed and evaluated with HCFA staff. The final decision on all APG modifications represents a consensus between the project staff and HCFA staff.

The APG analysis reports were used extensively throughout the reevaluation process. The reports were reviewed to identify clinically meaningful patterns that would suggest any of the following types of revisions.

- The collapsing together of specific combinations of APGs
- The subdivision of a specific APG into two or more APGs
- The reassignment of specific HCPCS codes or ICD-9-CM diagnosis codes to different APGs

The process of reevaluating the APG definitions was highly iterative. As the APGs were redefined, the charges and cost summary statistics in the APG analysis reports were recomputed, and the reports were reviewed again. The process was repeated numerous times. The overall objective of the process was to have clinically similar groups of patients with similar resource use, but to achieve these objectives with as few APGs as possible.

Summary of Differences Between APG Version 1.0 and Version 2.0

Version 2.0 of the APGs has 282 APGs plus 8 error APGs, whereas Version 1.0 of the APGs had 298 APGs plus one error APG. Appendix J contains a description of the rationale for and nature of all APG Version 2.0 modifications. Table 4.1 contains the number of APGs by the different APG types.

While the total number of APGs is relatively similar, the vast majority of APGs had some significant modifications. Table 4.2 shows the type of APG change and the number of APGs that had that type of change.

APG Type	Version 1.0	Version 2.0
Significant Procedure	145	126
Radiological Significant Procedure	0	5
Mental Health and Substance Abuse Significant Procedure	0	8
Medical	80	83
Laboratory	23	20
Ancillary Radiology	20	11
Pathology	2	3
Anesthesia	1	1
Ancillary Tests and Procedures	15	18
Chemotherapy	3	5
Incidental	8	2
Admitted or Died	1	0
Error	1	8
Total	299	290

Table 4.1 Number of APGs by APG Type

There are 33 APGs that were defined with the identical CPT-4 or ICD-9-CM codes. Appendix K lists all the APGs that were unchanged. Version 1.0 APGs were defined using 1989 HCPCS codes and 1990 ICD-9-CM codes. Version 2.0 APGs are defined using 1995 HCPCS and ICD-9-CM codes. For the portions of HCPCS relevant to APG definitions, there were 1348 codes deleted and 1438 new codes added between 1989 and 1995. For ICD-9-CM diagnosis codes, there were 145 codes deleted and 615 new codes added between 1990 and 1995. There are 36 APGs that changed solely as a result of new or deleted codes. These APGs are also listed in Appendix K. There are 158 APGs that were changed as a result of movement of individual codes into or out of the APG. These APGs are also listed in Appendix K. There were 72 Version 1.0 APGs that were deleted and 63 Version 2.0 APGs that are new. These APGs are also listed in Appendix K.

Type of APG Change	Number of APGs
Unchanged APGs	33
APGs changed only due to deleted or new codes	36
APGs with codes modified	158
APGs deleted	72
New APGs added	63

Table 4.2 Type of APG Changes

Major APG Modifications

In addition to specific APG modifications, there were a number of structural modifications made in Version 2.0 of the APGs.

Elimination of the Admitted or Died APG

In Version 1.0 of the APGs, there was a medical APG defined based on whether the patient died or was admitted to the hospital (APG 959). A review of the cost of patients in this APG showed that they were not significantly different from the APGs to which they would have otherwise been assigned. Thus, APG 959 was eliminated.

Elimination of Significant Procedure Consolidation

Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of the determination of payment. Significant procedure consolidation was included in APG 1.0 so that the separate coding of the constituent parts of a procedure would not result in multiple significant procedure APGs being assigned. Thus, significant procedure consolidation performed essentially an editing function. In the inpatient PPS system, the editing function (i.e., the Medicare Code Editor) and the DRG grouping are distinct processes. Since HCFA has developed edit logic for ambulatory claims, which eliminates the need for significant procedure consolidation, the significant procedure consolidation was eliminated.

Additional Significant Procedure APGs

Five radiological APGs that were previously considered ancillary APGs were made significant procedure APGs. These radiological APGs were interventional and met the definition of a significant procedure. The mental health therapies (e.g., group therapy) were also made a significant procedure. In Version 1.0 of the APGs, the mental health therapies were assigned to a medical APG. If there was more than one type of mental health therapy performed, the patient was assigned a single medical APG based on a hierarchical ordering of the mental health therapies. It was decided that patients with multiple, distinct, mental health therapies should be assigned multiple APGs to better reflect the services being rendered. Categorizing the mental health therapies as a significant procedure accomplished this objective.

Partial Hospitalization APGs

The partial hospitalization of mental health and substance abuse patients is becoming a more common treatment modality. Currently, there are no procedure codes available to identify partial hospitalization. Four partial hospitalization APGs were created (APGs 282, 283, 284 and 285) in anticipation that such codes will be available in the future.

Elimination of the Use of Age and Sex

Patient age and sex were sometimes used to define medical APGs in Version 1.0. In Version 2.0, all use of patient age and sex was eliminated.

The effect of these structural changes is to simplify the APG system. For example, the elimination of significant procedure consolidation has the effect of making the system easier to use. Previously, it was difficult to determine the number of significant procedure APGs that would be paid for a patient with multiple related codes present on the bill. Now, the logic is simplified and the number of APGs to be paid is apparent. In addition, three variables that were previously required to determine the APG assignment are no longer necessary (age, sex, and discharge status).

Appendix L contains the final list of Version 2.0 APGs. The Version 2.0 APGs are organized in categories similar to the MDCs in the DRGs. The Version 2.0 APGs have been completely renumbered.

Overview of APG Assignment Logic

Figure 4.1 provides an overview of the APG Version 2.0 assignment logic. Patients with any significant procedures or therapies are assigned to one or more significant procedure APGs. If there are no significant procedures present and there is a medical visit indicator, the patient is assigned to a medical APG. If there is neither a significant procedure nor a medical visit indicator present, but there are ancillary tests or procedures present, then the patient is only assigned one or more ancillary APGs. If there is no significant procedure, medical visit indicator or ancillary services present, the claim is considered an error.

Figure 4.1 Overview of APG Assignment Logic

CHAPTER 5

Evaluation of the APGs with Medicare Claims

Evaluation of the APGs

The evaluation of the APGs consisted of two separate analyses.

- The statistical performance of the APGs was measured by computing relative weights for each APG and comparing the APG based payments to historical hospital cost.
- An APG impact simulation was performed across different formulations of an APG system for different categories of hospitals.

Costs were imputed by using hospital specific departmental cost-to-charge ratios to convert charges to cost. Historical cost provided a measure of the relative amount of hospital resources used to treat a patient during an outpatient visit. In general, differences in imputed cost reflect differences in the hospital services provided. On a per claim basis, the statistical analysis of the APGs compared the total APG payment for a claim to the historical cost for the claim. The expectation was that the total APG payment would reflect the relative variation in historical costs. In a few cases during the development of the APGs, decisions were made, on clinical grounds, not to have the APGs reflect certain differences in historical charging practices that did not appear to reflect differences in resource use. For example, differences in historical charges for setting a fracture with and without manipulation are not reflected in the APGs. Thus, there are some differences between the APG payments and historical charges and imputed cost that were caused by intentional departures from historical charging practices. Despite these intended

differences, the combined payment effect of the aggregation of individual procedures and diagnoses into APGs, the ancillary packaging and the discounting needs to be understood in comparison to historical cost. The evaluation of the APGs determined APG payments based on alternative methods for computing the APG relative weights, alternative packaging lists, alternative discounting rules, alternative outlier policies and alternative windows of time. The resulting APG payments were compared to historical costs using several statistical measures. In addition, each component of the APG system was simulated in terms of its relative impact on different categories of hospitals. An overview of the APG system is shown in Figure 5.1.

Computing APG Relative Weights

Relative weights for each APG were computed. Relative weights can be computed based on either historical charges or cost. Payment results were simulated using relative weights computed from both charges and cost in order to determine if substantial differences exist between APG weights computed based on charges and cost. The APG relative weights for significant procedure or medical APGs include the costs associated with any ancillaries that are packaged into these APGs. Three alternative lists of packaged ancillaries were examined in the APG impact simulations. The three alternative packaging lists are summarized in Table 5.1.

The cost of medical surgical supplies and drugs, except for chemotherapy are always packaged and included in the APG relative weights. The cost of all incidental services (i.e., APG 421) are also always packaged and included in the APG relative weights. The limited packaging option only packages the anesthesia services. The simple packaging option adds simple ancillary tests to the lists of packaged ancillaries. The full packaging option adds some additional ancillary services, plus some minor medical services, to the list of packaged ancillaries.

Using charges and the three different packaging options, three sets of charge-based APG relative weights were computed. In addition, using costs and the three different packaging options, three sets of cost based APG relative weights were computed. The relative weights were computed based on the average cost or charge in each APG. In order to obtain an accurate estimate of the average value, it was necessary to eliminate the extreme charge or cost values from the computation of the average. In the computation of the inpatient DRG relative weights, claims with charges that were more than three standard deviations above the mean of the log of charges were eliminated. The same method of eliminating extreme charge or cost values was used in computing the six sets of APG relative weights. The six sets of APG relative weights are contained in Appendix M. For each significant procedure and medical APG, the following information is displayed in Appendix M: the number of claims, the percent of claims included in the computation of the

Type of Claim	Payment Included in Base APG	Additional Payment
Significant Procedure or Therapy	Packaged Ancillaries Incidental Procedures Supplies Drugs Except Chemotherapy Medications Anesthesia	Additional Significant Procedures are Discounted Nonpackaged Ancillaries Chemotherapy Medication
Medical Visit	Packaged Ancillaries Incidental Procedures Supplies Drugs	Nonpackaged Ancillaries
Ancillary Only		All Ancillaries Paid Separately

Figure 5.1 APG System

Full	Simple	Limited	APG	
X	X		310	Plain Film
X	X	X	321	Anesthesia
X	X		332	Simple Pathology
X	X		343	Simple Immunology Tests
X	X		345	Simple Microbiological Tests
X	X		347	Simple Endocrinology Tests
X	X		349	Simple Chemistry Tests
X	X		350	Basic Chemistry Tests
X	X		351	Multichannel Chemistry Tests
X	X		356	Simple Clotting Tests
X	X		358	Simple Hematology Tests
X	X		359	Urinalysis
X	X		360	Blood and Urine Dipstick Tests
X			371	Simple Pulmonary Function Tests
X	X		373	Cardiogram
X	X		383	Intro of Needle and Catheter
X			384	Dressings and Other Minor Proc
X			385	Other Misc Ancillary Proc
X			386	Biofeedback and Other Training
X			411	Psychotropic Med Management

Table 5.1 Alternative APG Packaging Options

relative weight, the coefficient of variation, the relative weight, the percent of the relative weight derived from direct charges or cost, and the percent of the relative weight derived from packaged ancillaries. For each ancillary APG, the following information is displayed in Appendix M: the number of revenue trailers, the percent of the revenue trailers used in the computation of the relative weight, the relative weight, and the coefficient of variation. The relative weights were computed by dividing the average trimmed charge or cost in each APG by the overall average trimmed charge or cost. The overall trimmed average charge or cost was computed as the average charge or cost *per claim* across all significant procedure, medical and ancillary only claims. Thus, for ancillary APGs the average charge or cost was computed on a *per revenue* trailer basis and was converted to a relative weight by dividing by a *per claim* average charge or cost.

The relative weights computed from charges and cost were essentially the same. The Pearson correlation coefficient between charge based and cost based relative weights, with limited, simple and full packaging, was 0.990,

0.991 and 0.992, respectively. However, due to the lower cost-to-charge ratio for ancillary departments, the relative weights for ancillary APGs tend to be proportionately lower for cost based weights than for charge based weights.

Table 5.2 contains the overall percent of claims or revenue trailers trimmed from the computation of the relative weights. As can be seen from this table, the percent of claims or revenue trailers trimmed from the computation of the relative weights is only a fraction of one percent.

		Charges			Cost		
	Count	Full Package	Simple Package	Limited Package	Full Package	Simple Package	Limited Package
Significant Procedure Claims	1,567,263	0.25	0.25	0.29	0.26	0.26	0.28
Medical Claims	2,186,728	0.10	0.10	0.37	0.11	0.11	0.26
Significant Procedure and Medical Claims Combined	3,753,991	0.17	0.16	0.34	0.17	0.17	0.27
Ancillary Revenue Trailers	25,479,800	0.28	0.28	0.28	0.26	0.26	0.26

Table 5.2 Percent of Claims or Revenue Trailers Excluded from Computation of Relative Weights

Table 5.3 contains the overall percent of relative weights derived from packaged ancillaries for the six sets of relative weights. In general, the percent of the relative weight from packaged ancillaries tends to be lower for cost based relative weights than for charge based relative weights. This reflects the relatively low cost-to-charge ratios associated with the ancillary departments. The medical APGs have a much higher percentage of the APG relative weight from packaged ancillaries than the significant procedure APGs. For the cost based relative weights with full packaging, the relative weight with the highest percent of the APG relative weight from packaged ancillaries is the medical APG for chest pain with cardiac enzymes to rule out myocardial infarction (APG 573), at 46.2 percent. The high percent of packaged ancillaries associated with this APG is the result of the packaging of the extensive laboratory tests that are performed for this type of patient. In general, the percent of the relative weight from packaged ancillaries tends to

		Charge Based Relative Weights			Cost Based Relative Weights		
	Count	Full Package	Simple Package	Limited Package	Full Package	Simple Package	Limited Package
Significant Procedure Claims	1,567,263	11.90	11.64	3.62	9.24	9.00	2.51
Medical Claims	2,186,728	45.38	45.20	0.94	31.34	31.18	0.52
Significant Procedure and Medical Claims Combined	3,753,991	20.00	19.76	3.20	15.44	15.22	2.07

Table 5.3 Percent of Relative Weights Derived from Packaged Ancillaries

be 3 to 4 times higher for medical APGs than for significant procedure APGs. The high percent of the relative weights from packaged ancillaries for medical patients is primarily the result of the relatively low payment for a medical claim. The APG with the lowest percent of the APG relative weight from packaged ancillaries is the significant procedure APG for laser eye procedures (APG 213), at 0.22 percent.

Coefficient of Variation for APGs and DRGs

Appendix M contains the coefficient of variation for each APG for the data used to compute the six sets of relative weights. Table 5.4 contains the weighted coefficient of variation for each type of APG. The weighted coefficient of variation was computed by weighting the coefficient of variation of each APG by the percent of claims (or revenue trailers, for ancillary service APGs) in that APG and summing across all the APGs.

		Charges			Cost		
	Count	Full Package	Simple Package	Limited Package	Full Package	Simple Package	Limited Package
Significant Procedure Claims	1,567,263	0.748	0.752	0.754	0.758	0.762	0.784
Medical Claims	2,186,728	1.100	1.099	1.018	0.970	0.969	0.977
Significant Procedure and Medical Claims Combined	3,753,991	0.953	0.955	0.904	0.881	0.883	0.897
Ancillary Revenue Trailers	25,479,800	0.707	0.707	0.707	0.698	0.698	0.698

Table 5.4 Weighted Coefficient of Variation for APGs

The weighted coefficient of variation was relatively unaffected by the extent of the ancillary packaging. The weighted coefficient of variation for medical claims and ancillary revenue trailers is lower for cost than for charges. The weighted coefficient of variation is substantially lower for significant procedure APGs than for medical APGs.

In order to provide a comparison to the DRGs, a random sample of 720,632 Medicare inpatient discharges from FY 1994 was obtained. Using Version 12.0 of the DRGs, high charge trim points were computed using the same three standard deviations above the mean of the log of charges trimming method that was applied to the APGs. The trim eliminated 0.39 percent of the claims. The charge values were standardized charges that were adjusted to account for variation in hospital costs due to factors such as wage rates and teaching programs. The weighted coefficient of variation of the standardized charges for the DRGs is shown in Table 5.5.

As can be seen from a comparison of Table 5.4 and Table 5.5, the weighted coefficient of variation for the APGs is higher than the weighted coefficient of variation for the DRGs. The standardized charges used with the DRGs would be most comparable to cost with full packaging. The overall weighted

coefficient of variation for APGs for cost with full packaging is 0.881 compared to 0.741 for DRGs.

	Weighted Coefficient of Variation
Procedure Discharges	0.653
Medical Discharges	0.777
Procedure and Medical Discharges Combined	0.741

Table 5.5 Weighted Coefficient of Variation of Standardized Charges for DRGs, Based on Trimmed Data

Frequency of APGs

Table 5.6 summarizes, for the analysis database, the number of claims and total charge and cost for the three different types of claims. The charges and cost reported in Table 5.6 contain all ancillaries on the claim, including both packaged and unpackaged ancillaries. The claims in Table 5.6 include claims with multiple significant procedures and claims that were trimmed in the computation of the APG relative weights.

	Number of Claims	Percent Claims	Avg Chg	Total Chgs ($Mill)	Percent Chgs	Avg Cost	Total Cost ($Mill)	Percent Cost
Significant Procedure Claims	1,943,837	17.03	1061.75	2063.87	55.25	576.39	1122.40	55.58
Medical Claims	2,187,170	19.16	226.34	495.04	13.25	147.15	321.84	15.96
Ancillary Only Claims	7,281,731	63.80	161.58	1176.56	31.50	78.79	573.74	28.46

Table 5.6 Number of Claims and Total Charges and Cost by Type of APG

Although significant procedure claims constitute only 17.03 percent of the claims, they account for 55.25 percent of the charges and 55.58 percent of the cost. Conversely, although ancillary only claims constitute 63.80 percent of the claims, they account for only 31.50 percent of the charges and 28.46 percent of the cost. The lower percent of cost associated with ancillary only claims reflects the lower cost-to-charge ratios associated with ancillary departments.

The most frequent significant procedure APGs were:

214 Cataract procedures (158,640)

117 Lower gastrointestinal endoscopy (118,377)

071 Exercise tolerance tests (106,033)

255 Miscellaneous radiological procedures with contrast (93,438)

051 Pulmonary tests (88,916)

Claims for therapies, such as physical therapy and dialysis, are often batch billed. Since batch bills could not be subdivided into individual visits, those claims were excluded from the analysis database. Thus, APGs representing these therapies are under represented in the analysis database.

Psychotherapy is treated as a significant procedure in Version 2.0 of the APGs, although such visits would generally be thought of as medical visits. There were a substantial number of brief psychotherapy (APG 286) claims (i.e., 101,119) in the analysis database.

The most frequent medical APGs were:

623 Simple musculoskeletal diseases except back (132, 005)

572 Hypertension (128,040)

464 Fractures, dislocations and sprains (124,945)

597 Other simple gastrointestinal diseases (108,093)

705 Nonspecific signs and symptoms and other contacts with health services (102,944)

The most frequent ancillary APGs were:

358 Simple hematology tests (3,780,586)

351 Multichannel chemistry (2,844,021)

310 Plain film (2,647,171)

383 Introduction of needle and catheter (2,100,985)

350 Basic chemistry tests (1,493,036)

APGs 282 to 285 have no patients, since current HCPCS codes do not identify partial hospitalizations. These APGs were created for future use when partial hospitalizations can be identified. There were 14 APGs with less than 100 patients. Six of these APGs relate to maternity or child care, which would rarely occur in the Medicare population (APGs 171, 173, 174, 175, 493 and 702). Other APGs represent procedures that are infrequent but expensive, such as neurostimulator implantation. As more complex procedures are performed in an outpatient setting, these APGs will increase in frequency. The low volume of some APGs simply reflects that some CPT-4 codes are not commonly recorded, such as fitting of contact lenses or activity therapy. In the inpatient PPS some DRGs also have low volume. For FY 1991, although 9.9 million inpatient claims were used to compute the DRG payment rates, there were still 40 DRGs that had payment rates based on less than 100 patients.

Evaluation of Relative Weights

In general, the relative weights are quite consistent with expectations. Using the relative weights based on cost with full packaging, the APGs with the

highest relative weight are low volume, significant procedure APGs involving expensive medical surgical supplies or equipment:

231 Cochlear device implantation (73.024)
78 Pacemaker insertion and replacement (51.219)
152 Insertion of penile prosthesis (44.078)
197 Neurostimulator and ventricular shunt implantation (39.583)
131 Renal extracorporeal shock wave lithotripsy (39.272)

The significant procedure APGs with the lowest relative weights are the therapy APGs that usually involve a series of visits. The non-therapy significant procedure APGs with the lowest relative weights are:

001 Photochemotherapy (0.431)
005 Nail procedures (0.679)
093 Phlebotomy (0.860)
237 Simple audiometry (1.105)
194 Nerve and muscle tests (1.285)

The medical APGs with the highest relative weights are:

611 Major signs, symptoms or findings (4.123)
573 Chest pain with cardiac enzymes to rule out acute myocardial infarction (3.727)
654 Fluid and electrolyte disorders (3.310)
693 Complex immunologic and hematologic diseases (2.786)
501 Complex infectious diseases (2.66)

The medical APGs with the lowest relative weights are:

704 Aftercare (0.630)
631 Disease of nails (0.645)
703 Contraception and procreative management (0.684)
532 Refraction disorders (0.697)
671 Benign prostatic hypertrophy (0.700)

For ancillary service APGs, the APGs with highest relative weights are the APGs for radiological tests that use expensive equipment (e.g., MRI at 5.734, have the highest relative weight). The ancillary APG with the lowest relative weight is Introduction of Needle and Catheter (APG 383), at 0.032. Laboratory tests tend to have relatively low relative weights (e.g., Blood and Urine Dipstick Tests, APG 360, at 0.069, has the second lowest relative weight). The ancillaries in the full packaging list are shown in Table 5.7. The packaged ancillaries in the full packaging list associated with laboratory tests all have relative weights less than 0.251.

Count	Relative Weight	APG	Description
2,647,171	0.557	310	Plain Film
325,767	0.874	321	Anesthesia
645,170	0.331	332	Simple Pathology
221,774	0.154	343	Simple Immunology Tests
889,172	0.165	345	Simple Microbiological Tests
684,027	0.188	347	Simple Endocrinology Tests
1,299,622	0.169	349	Simple Chemistry Tests
1,493,036	0.096	350	Basic Chemistry Tests
2,844,021	0.251	351	Multichannel Chemistry Tests
1,324,932	0.096	356	Simple Clotting Tests
3,780,586	0.106	358	Simple Hematology Tests
978,410	0.081	359	Urinalysis
144,135	0.069	360	Blood and Urine Dipstick Tests
147,924	0.494	371	Simple Pulmonary Function Tests
886,603	0.274	373	Cardiogram
2,100,985	0.032	383	Intro of Needle and Catheter
1,602	0.577	384	Dressings and Other Minor Proc
2,837	1.392	385	Other Misc Ancillary Proc
130	0.579	386	Biofeedback and Other Training
1,210	0.607	411	Psychotropic Med Management

Table 5.7 APG Relative Weights for Packaged Ancillaries, Based on Cost with Full Packaging

The relative weight for Other Miscellaneous Ancillary Procedures (APG 385) is surprisingly high. This may reflect that some of the costs associated with the medical visit may be reported on the revenue trailer containing APG 385.

Overall, the relative weights are consistent with clinical expectations. Thus, all APGs that have the descriptive term "complex" have a higher relative weight than clinically similar APGs that have the descriptive term "simple". For example, using the cost based relative weights with full packaging, APG 3 (Complex Incision and Drainage) has a relative weight of 5.055, in contrast to APG 4 (Simple Incision and Drainage), which has a relative weight of 2.757.

However, there are several pairs of APGs which have paradoxical relative weights and thus merit comment. APG 76 (Diagnostic Cardiac Catheterization) has a higher relative weight than APG 77 (Angioplasty and

Transcatheter Procedures). It would be expected that the therapeutic procedure would have a higher relative weight than the diagnostic procedure. Despite this anomaly, it is important that these two groups be maintained as distinct APGs for clinical consistency.

The APGs pertaining to chemotherapy also provide some contradictory relative weights. APG 91 (Chemotherapy by Extended Infusion) has a lower relative weight than APG 92 (Chemotherapy Except by Extended Infusion). Likewise, the APGs for the Chemotherapeutic Drugs also provide contradictory relative weights. The problem here is that the development of the APGs for chemotherapeutic drugs was based on the average wholesale price for specific medications. The data used to create the relative weights was based on actual charges submitted by hospitals. Hospitals pay very differently for the same medications depending on the financial arrangement negotiated with the pharmaceutical vendor. This is a likely reason for the contradictory relative weights for chemotherapeutic drugs.

None of the discrepancies observed were significant enough to cause any reconsiderations of the definition of any of the APGs. As more accurate data is collected and used to compute APG relative weights, APGs should conform more closely to clinical expectations. The relatively minor discrepancies are not surprising, since the APG relative weights represent the first attempt to use CWF data to compute relative weights. The initial DRG payment rates, used in the first two years of PPS, contained several discrepancies. For example, for five pairs of DRGs, patients with a significant complication or comorbidity were paid less than patients without a significant complication or comorbidity (i.e., DRG pairs 135, 136; 168, 169; 221, 222; 403, 404; and 452, 453). Once the DRG payment rates were recomputed with more accurate data, all the discrepancies were eliminated. The experience with the DRGs emphasizes the importance of relying on clinical expectations when developing a patient classification system.

Statistical Performance of APGs

For each claim in the analysis database, a total APG payment was simulated using 13 different formulations of the APG system (i.e., different ancillary packaging lists, discounting rules, etc.). The relationship between the historical cost and the total APG payment was compared for each of the 13 formulations of the APG system using three different statistical measures

- Reduction in variance (R^2)
- Normalized mean absolute difference
- Mean percent absolute difference

The formula for each of the three statistical measures is contained in Appendix N.

A least squares regression measures the ability of the total APG payment amount to predict the historical cost. The least square regression is referred to as R^2 and provides a measure of the amount of variance in cost explained by

the APG payment APG system. Positive values that approach 1.0 for R^2 would indicate that the relative value of the total APG payment closely approximates the relative value of the historical cost.

The mean absolute difference was computed by taking the absolute value of the difference between historical cost and APG payment for each claim, summing over all claims and dividing by the number of claims. The mean absolute difference can be normalized by dividing it by the average cost per claim and then multiplying that value by 100 in order to express the result as a percentage. Thus, a normalized mean absolute difference of 50.0 would mean that the average difference between cost and APG payment is 50 percent of the average cost. Lower values for the normalized mean absolute difference indicate less difference between historical cost and APG payment. In the computation of R^2, the difference between cost and APG payment is squared. Due to the squaring of differences, R^2 can be impacted significantly by a few claims with large differences. Since the normalized mean absolute difference uses absolute values instead of squaring, it is less sensitive to large differences between payment and cost.

The mean percent absolute difference for each claim was computed by taking the absolute value of the difference between the historical cost and the total APG payment, dividing by the historical cost for the claim, summing over all claims and dividing by the number of claims. The mean percent absolute difference is the average value of the percent difference between historical cost and APG payment. Lower values for the mean percent absolute difference indicate less difference between historical cost and APG payment. Since the underlying statistic being aggregated across claims is a percent, a difference of $50 between cost and payment on a claim with a cost of $100 has the same impact as a difference of $500 between cost and payment on a claim with a cost of $1,000. The mean percent absolute difference can be significantly impacted by a few claims with low cost but a large difference between cost and payment.

The basis of the APG relative weights (i.e., cost or charges), the extent of ancillary packaging, the outlier policy, the level of discounting and the window of time for ancillary packaging are five components of an APG system for which alternative approaches exist. The APG evaluation examined the impact on R^2, normalized mean absolute difference and mean percent absolute difference of alternative approaches to each of these components as follows:

Basis of Relative Weights

The APG relative weights can be computed based on charges or cost. Currently, the inpatient DRG relative weights are computed using charges. Separate APG simulations were performed using relative weights computed based on charges and cost.

Ancillary Packaging

Separate APG simulations were performed using the full, simple and limited ancillary packaging lists contained in Table 5.1.

Outlier Policy

Outliers are atypical cases that have costs much higher than the APG payment amount. Outlier payments essentially represent a stop loss provision that protects providers from extreme losses on any individual patient. Cost outlier values were established for each significant procedure and medical APG. If the cost of the patient exceeds the cost outlier value, then the total payment for the patient would be the standard APG payment amount plus 100 percent of the difference between the actual cost and the cost outlier value. The cost outlier value was established based on a specified number of standard deviations above the mean for each APG. The precise number of standard deviations above the mean was established such that a specified percentage of total payments would be associated with outlier payments. Thus, the number of standard deviations varied depending on the exact percentage of total payments associated with outlier payments. Since there are some administrative costs associated with outlier payments, the cost outlier value was constrained to be, at a minimum, $1700 for significant procedure APGs and $350 for medical APGs. Thus, for patients whose cost exceeds the cost outlier value, the total payment would be:

Total payment = APG payment + (actual cost - outlier value)

The complete formula for computing the outlier payments is contained in Appendix O. Outlier payments are only associated with significant procedure and medical claims; there are no outlier payments associated with ancillary only claims. Three outlier alternatives were evaluated: no outliers, one percent of total payments associated with outlier payments and three percent of total payments associated with outlier payments. The inpatient DRG system currently has 5.1 percent of total payments associated with outlier payments. A 5.1 percent of total payments associated with outlier payments was not evaluated since it would produce a large volume of claims with outlier payments.

Discounting

If there are multiple significant procedures, the significant procedure with the highest relative weight is paid at 100 percent and each additional significant procedure is discounted by 50 percent. The 50 percent multiple significant procedure discounting was included in all APG systems that were evaluated. In addition, a 20 percent discounting of multiple ancillaries in the same APG was evaluated.

Window of Time for Ancillary Packaging

Packaged ancillary services delivered on the day of a significant procedure or medical visit are always included in the APG payment. The impact of expanding the window of time for including packaged ancillaries in the APG payment was evaluated. A three day and seven day window of time around the visit was evaluated.

The above components of an APG system were configured to produce 13 different formulations of an APG system. The 13 different APG systems are

summarized in Table 5.8. The definition of the alternative packaging options is contained in Table 5.1. For each of the APG systems, the APG payment amount for each patient was computed and compared to patient cost by computing an overall R^2, normalized mean absolute difference and mean percent absolute difference. The APG payment levels for each of the APG simulations were set such that the aggregate APG payment, including any outlier payments, was equal to the aggregate cost across all patients. Thus, each APG simulation was performed on a budget-neutral basis. The APG simulation adjusted each hospital's APG payments for variations in wage rates using the 1993 Medicare inpatient PPS wage rate adjustment factors. In applying the wage rate adjustment factors, it was assumed that each hospital had 71.4 percent of its cost associated with labor. This is the same percentage used in the inpatient PPS. Appendix O contains the formulas describing the complete APG simulation, including the process of accomplishing budget neutrality.

The data used to compute the relative weights excluded all claims with multiple significant procedures because it was not possible to determine to which significant procedure the individual charge items (e.g., pharmaceuticals, medical-surgical supplies, etc.) or the packaged ancillaries should be allocated. There were 376,574 claims with multiple significant procedures. The APG simulations included all patients with multiple significant procedures. When the relative weights were computed, patients with extreme charge or cost values were excluded based on a three standard deviations above the mean of the log of charges or cost trimming method. The APG simulations did not exclude patients with extreme charge or cost values, and all 11,412,738 claims in the analysis database were included in the APG system simulations.

Comparing Version 1.0 and Version 2.0 of the APGs

The comparable statistics reported in the original research for Version 1.0 of the APGs are shown in Table 5.9. The Version 1.0 statistics were computed using charge based weights, full packaging, significant procedure consolidation, both significant procedure and ancillary discounting, and a window of service of one day. The Version 1.0 statistics were computed relative to charges and not cost. The statistics reported in the original APG Version 1.0 research were R^2 and mean percent absolute difference.

The Version 1.0 APG analysis did not contain any identification of outliers. However, the APG Version 1.0 analysis did present the results both trimmed and untrimmed. The APG Version 1.0 analysis defined high and low charge trim points that resulted in the exclusion of 5.12 percent of the significant procedure claims, 5.48 percent of the medical claims and 5.26 percent of the ancillary revenue trailers. The trimmed patients were *excluded* from the APG Version 1.0 results, while outliers in the APG Version 2.0 are *included* in the

APG System	Basis of Relative Weights	Ancillary Packaging	Outliers	Ancillary Discounting	Window of Time
1	Cost	Limited	1%	No	Same Day
2	Charge	Limited	1%	No	Same Day
3	Cost	Full	1%	No	Same Day
4	Charge	Full	1%	No	Same Day
5	Cost	Simple	1%	No	Same Day
6	Cost	Limited	None	No	Same Day
7	Cost	Full	None	No	Same Day
8	Cost	Full	3%	No	Same Day
9	Cost	Limited	3%	No	Same Day
10	Cost	Limited	1%	Yes	Same Day
11	Cost	Full	1%	Yes	Same Day
12	Cost	Full	1%	No	Three Days
13	Cost	Full	1%	No	Seven Days

Table 5.8 Components of Alternative APG Systems

results. Due to the large percentage of claims excluded as outliers in the original APG Version 1.0 research, it is not possible to compare the trimmed results for Version 1.0 and Version 2.0 of the APGs. However, the untrimmed results can be compared. A special APG Version 2.0 simulation was run using charge based relative weights, full packaging, no outliers, both significant procedure and ancillary discounting, and a same day window of time. As was done with APG Version 1.0, the APG system was used to predict *charges* instead of cost. Table 5.9 shows the untrimmed results for Versions 1.0 and

	R^2		Mean Percent Absolute Difference	
	Version 1.0	Version 2.0	Version 1.0	Version 2.0
Significant procedure visits	0.52	0.670	113.05	100.70
Medical visits	0.18	0.306	207.97	212.02
Significant procedure and medical visits combined	0.58	0.597	171.59	159.64
Ancillary only visits	0.67	0.774	56.58	65.75

Table 5.9 Summary Statistics for APG Versions 1.0 and 2.0

2.0 of the APGs. The untrimmed R^2 results for Version 2.0 of the APGs are higher than Version 1.0 and the mean percent absolute difference is roughly comparable.

Comparing Version 2.0 APGs and DRGs

In order to assist in the interpretation of the three statistical measures, the Medicare inpatient data was used to compute the same statistics for the DRGs. In the payment model used for the DRG analysis, the payment for each patient was computed as the average standardized charge for the DRG to which the patient was assigned. The results for the DRGs are shown in Table 5.10.

	R^2		Mean Percent Absolute Difference		Normalized Mean Absolute Difference	
	Untrimmed	Trimmed	Untrimmed	Trimmed	Untrimmed	Trimmed
Procedure Discharges	0.425	0.503	71.90	69.05	48.49	46.67
Medical Discharges	0.267	0.366	91.33	87.51	57.38	55.33
Procedure and Medical Discharges Combined	0.394	0.476	84.64	81.16	52.36	50.43

Table 5.10 DRG Summary Statistics by Type of DRG

The APG simulation that most closely approximates the untrimmed DRGs is APG System 7, which uses cost based weights with full packaging, no outliers, significant procedure discounting, no repeat ancillary discounting and a same day window of time. The APG simulation that most closely approximates the trimmed DRGs is APG System 3, which is the same as APG System 7 except that there is one percent outlier payments. Table 5.11 summarizes the results of these simulations.

The R^2 for untrimmed and trimmed (i.e., with outliers for APGs) procedure and medical claims combined is higher for APGs than for DRGs (i.e., 0.575 and 0.660 for APGs versus 0.394 and 0.476 for DRGs). For procedure claims,

	R^2		Mean Percent Absolute Difference		Normalized Mean Absolute Difference	
	APG System 7	APG System 3	APG System 7	APG System 3	APG System 7	APG System 3
Significant Procedure Visits	0.601	0.668	104.09	102.68	41.76	40.82
Medical Visits	0.264	0.588	169.24	166.79	60.31	56.41
Significant Procedure and Medical Visits Combined	0.575	0.660	138.58	136.62	45.90	44.30

Table 5.11 APG Summary Statistics by Type of APG

the APGs have a higher R^2 than the DRGs (i.e., 0.601 and 0.668 for APGs versus 0.425 and 0.503 for DRGs). For medical claims the DRGs have a slightly higher R^2 than the APGs for untrimmed claims but a lower R^2 for trimmed claims (i.e., 0.264 and 0.588 for APGs versus 0.267 and 0.366 for DRGs). The higher R^2 for the APGs means that the APGs predict historical outpatient costs better than the DRGs predict historical standardized inpatient charges.

The normalized mean absolute difference for untrimmed and trimmed (i.e., with outliers for APGs) procedure and medical claims combined is lower for APGs than for DRGs (i.e., 45.90 and 44.30 percent for APGs versus 52.36 and 50.43 percent for DRGs). The mean percent absolute difference for untrimmed and trimmed (i.e., with outliers for APGs) procedure and medical claims combined is higher for APGs than for DRGs (i.e., 138.58 and 136.62 percent for APGs versus 84.64 and 81.16 percent for DRGs). Since APG claims have much lower costs than DRG claims, the higher values of mean percent absolute difference for APGs relative to DRGs is caused by low cost claims with large differences between cost and payment.

In general, the APGs perform well compared to DRGs. Indeed, for R^2 on trimmed data, which is the most commonly used statistical measure for comparisons, the APGs have an R^2 that is 38.7 percent higher than the DRGs (i.e., 0.660 for APGs versus 0.476 for DRGs). Thus, in general, the Version 2.0 APGs perform better in terms of the statistical measures than the Version 1.0 APGs or the inpatient DRGs. This means that Version 2.0 is a better predictor of historical costs and charges than Version 1.0 of the APGs or the inpatient DRGs.

Comparison of Alternative APG Systems

Table 5.12, Table 5.13 and Table 5.14 contain the R^2, normalized mean absolute difference and mean percent absolute difference for all 13 APG system simulations. In addition, Table 5.15 contains the percent of patients who received any outlier payment. Based on the results in these tables, the impact of each of the alternative formulations of the APG system was evaluated.

Cost Based and Charge Based Relative Weights

From Table 5.12, APG Systems 1 and 2 compare the effects of using relative weights based on charges and cost with the limited packaging option, while APG Systems 3 and 4 make the same comparison with the full packaging option. All four APG systems have one percent of payments associated with outliers, no ancillary discounting and a same day window of time. The R^2 for APG System 1 compared to APG System 2 is virtually identical, and the R^2 for APG System 3 compared to APG System 4 is also virtually identical. Thus, the cost of individual patients can be predicted equally well (i.e., obtain the same R^2) using relative weights computed from charges or relative weights computed from costs.

Alternative Packaging Lists

APG Systems 1, 3 and 5 use limited, full and simple packaging, respectively, with cost based relative weights, one percent of payments associated with outliers, no ancillary discounting and a same day window of service. The simple packaging and the full packaging have virtually identical R^2 results. The R^2 for significant procedure claims is 2.2 percent lower with full packaging (0.668 versus 0.683). For medical claims, the R^2 is 21.1 percent lower with full packaging than it is with limited packaging (0.588 versus 0.745). The lower R^2 for medical claims with the full packaging option reflects the combined effect of the variability in the use of ancillaries for medical visits coupled with ancillaries being a large percent of the cost of a medical visit.

Outliers

APG Systems 6, 1 and 9 use 0 percent, 1 percent and 3 percent of payments associated with outliers, respectively, with the limited packaging option, cost based relative weights, no ancillary discounting and a same day window of time. For significant procedure APGs, the 3 percent outlier option has the highest R^2, while the 1 percent outlier option is 10.1 percent lower (0.760 versus 0.683) and the no outlier option is 18.4 percent lower (0.760 versus 0.620). For medical APGs, the 3 percent outlier option has the highest R^2, while the 1 percent outlier option is 7.3 percent lower (0.804 versus 0.745) and the no outlier option is 45.4 percent lower (0.804 versus 0.439). Thus, there is a small reduction in R^2 if outlier payments are reduced from 3 percent to 1 percent, but a large reduction in R^2 for medical claims if outlier payments are eliminated entirely.

APG Systems 7, 3 and 8 use 0 percent, 1 percent and 3 percent payments associated with outliers with the full packaging option, cost based relative weights, no ancillary discounting and a same day window of service. For significant procedure APGs, the 3 percent outlier option has the highest R^2, while the 1 percent outlier option is 9.0 percent lower (0.734 versus 0.668) and the no outlier option 18.1 percent lower (0.734 versus 0.601). For medical APGs, the 3 percent outlier option has the highest R^2, while the 1 percent outlier option is 19.0 percent lower (0.726 versus 0.588) and the no outlier option is 63.6 percent lower (0.726 versus 0.264). Thus, with full packaging, there is a modest reduction in R^2 by reducing the outlier payments from 3 percent to 1 percent and a large reduction in R^2 for medical claims if outlier payments are eliminated entirely.

While the 3 percent outlier option has the highest R^2 it also results in significantly more claims having outlier payments. From Table 5.15, APG Systems 1 and 3, which use the 1 percent outlier option, have 1.277 percent and 1.241 percent of claims with outlier payments, respectively. APG Systems 8 and 9, which use the 3 percent outlier option have considerably more claims with outlier payments with 4.571 percent and 3.588 percent of claims with outlier payments, respectively.

APG Systems	Sig Proc	Medical	Medical Plus Sig Proc	Anc Only	Total	Basis Wghts	Anc Pkg	Out	Anc Dis	Window of Time
1	0.683	0.745	0.686	0.746	0.773	Cost	Lim	1%	No	Same Day
2	0.688	0.744	0.690	0.739	0.774	Chg	Lim	1%	No	Same Day
3	0.668	0.588	0.660	0.746	0.757	Cost	Full	1%	No	Same Day
4	0.669	0.589	0.661	0.739	0.756	Chg	Full	1%	No	Same Day
5	0.668	0.590	0.660	0.746	0.757	Cost	Sim	1%	No	Same Day
6	0.620	0.439	0.605	0.746	0.721	Cost	Lim	None	No	Same Day
7	0.601	0.264	0.575	0.746	0.701	Cost	Full	None	No	Same Day
8	0.734	0.726	0.733	0.746	0.804	Cost	Full	3%	No	Same Day
9	0.760	0.804	0.762	0.746	0.823	Cost	Lim	3%	No	Same Day
10	0.682	0.744	0.684	0.746	0.772	Cost	Lim	1%	Yes	Same Day
11	0.668	0.587	0.660	0.746	0.756	Cost	Full	1%	Yes	Same Day
12	0.665	0.592	0.657	0.747	0.755	Cost	Full	1%	No	3 Days
13	0.664	0.596	0.656	0.747	0.754	Cost	Full	1%	No	7 Days

Table 5.12 R^2 for Alternative APG Systems

APG Systems	Sig Proc	Medical	Medical Plus Sig Proc	Anc Only	Total	Basis Wghts	Anc Pkg	Out	Anc Dis	Window of Time
1	39.00	42.60	39.81	37.13	39.05	Cost	Lim	1%	No	Same Day
2	38.67	39.40	38.83	40.95	39.43	Chg	Lim	1%	No	Same Day
3	40.82	56.41	44.30	36.99	42.22	Cost	Full	1%	No	Same Day
4	40.67	53.03	43.42	40.36	42.55	Chg	Full	1%	No	Same Day
5	40.84	56.28	44.29	36.99	42.21	Cost	Sim	1%	No	Same Day
6	39.87	46.72	41.40	37.27	40.22	Cost	Lim	None	No	Same Day
7	41.76	60.31	45.90	37.10	43.40	Cost	Full	None	No	Same Day
8	38.33	50.91	41.14	36.82	39.91	Cost	Full	3%	No	Same Day
9	35.71	40.05	36.68	36.92	36.75	Cost	Lim	3%	No	Same Day
10	39.06	42.76	39.89	37.18	39.12	Cost	Lim	1%	Yes	Same Day
11	40.82	56.48	44.31	37.00	42.23	Cost	Full	1%	Yes	Same Day
12	40.75	56.71	44.36	37.05	42.36	Cost	Full	1%	No	3 Days
13	40.67	56.94	44.37	37.23	42.51	Cost	Full	1%	No	7 Days

Table 5.13 Normalized Mean Absolute Difference for Alternative APG Systems

APG Systems	Sig Proc	Medical	Medical Plus Sig Proc	Anc Only	Total	Basis Wghts	Anc Pkg	Out	Anc Dis	Window of Time
1	89.77	118.08	104.76	64.72	79.21	Cost	Lim	1%	No	Same Day
2	80.32	73.71	76.82	83.65	81.18	Chg	Lim	1%	No	Same Day
3	102.68	166.79	136.62	63.70	90.09	Cost	Full	1%	No	Same Day
4	95.28	126.51	111.81	81.52	92.48	Chg	Full	1%	No	Same Day
5	102.10	166.42	136.16	63.69	89.92	Cost	Sim	1%	No	Same Day
6	91.03	120.09	106.42	65.58	80.36	Cost	Lim	None	No	Same Day
7	104.09	169.24	138.58	64.52	91.33	Cost	Full	None	No	Same Day
8	99.73	161.77	132.58	62.09	87.61	Cost	Full	3%	No	Same Day
9	86.88	114.70	101.61	63.06	77.01	Cost	Lim	3%	No	Same Day
10	90.04	118.43	105.07	65.08	79.55	Cost	Lim	1%	Yes	Same Day
11	102.75	166.96	136.75	63.77	90.19	Cost	Full	1%	Yes	Same Day
12	101.68	168.50	137.07	64.01	90.89	Cost	Full	1%	No	3 Days
13	101.04	169.89	137.49	64.54	91.84	Cost	Full	1%	No	7 Days

Table 5.14 Mean Percent Absolute Differences for Alternative APG Systems

APG Systems	Sig Proc	Medical	Medical Plus Sig Proc	Basis Wghts	Anc Pkg	Out	Anc Dis	Window of Time
1	0.496	1.971	1.277	Cost	Lim	1%	No	Same Day
2	0.529	1.878	1.243	Chg	Lim	1%	No	Same Day
3	0.571	1.835	1.241	Cost	Full	1%	No	Same Day
4	0.580	1.815	1.234	Chg	Full	1%	No	Same Day
5	0.569	1.837	1.241	Cost	Sim	1%	No	Same Day
6	0.000	0.000	0.000	Cost	Lim	None	No	Same Day
7	0.000	0.000	0.000	Cost	Full	None	No	Same Day
8	3.027	5.944	4.571	Cost	Full	3%	No	Same Day
9	3.860	3.346	3.588	Cost	Lim	3%	No	Same Day
10	0.486	1.996	1.285	Cost	Lim	1%	Yes	Same Day
11	0.569	1.830	1.236	Cost	Full	1%	Yes	Same Day
12	0.538	1.732	1.171	Cost	Full	1%	No	3 Days
13	0.519	1.650	1.118	Cost	Full	1%	No	7 Days

Table 5.15 Percent of Claims with Outlier Payments

Ancillary Discounting

APG System 10 adds ancillary discounting to APG System 1. APG Systems 1 and 10 have limited packaging, with cost based relative weights, one percent of payments associated with outliers and a same day window of service. APG System 11 adds ancillary discounting to APG System 3. APG Systems 3 and 11 have full packaging, with cost based relative weights, one percent of payments associated with outliers and a same day window of service. The R^2 for APG Systems 1 and 10 and the R^2 for APG Systems 3 and 11 are virtually identical. Thus, there is virtually no reduction in R^2 from ancillary discounting.

Window of Time

In order to simulate a window of time of three days and seven days for APG Systems 12 and 13, respectively, it was necessary to collapse some of the ancillary only claims into a significant procedure or medical claim. Thus, if there was an ancillary only claim for a patient two days following a medical visit, the ancillary only claim was deleted and the ancillary services provided were incorporated into the medical visit claim. In addition, the expanded window of time created some ambiguous situations, which necessitated the exclusion of some additional claims. For example, if the same ancillary only claim occurred two days after a medical visit and two days prior to a significant procedure visit, then it would be ambiguous as to whether the ancillary only claim should be associated with the medical visit or the significant procedure visit. In this example, all three claims would be excluded from the analysis because of the ambiguity. Table 5.16 contains the reduction in the number of claims, by type of APG, for the three day and seven day window of time. As shown in Table 5.16, there were only a small percentage of significant procedure or medical claims eliminated due to ambiguities, and 3.02 percent and 6.65 percent of the ancillary only claims were collapsed or eliminated due to ambiguities for the three day and seven day window of time, respectively.

As a result of the expanded window of time, a larger proportion of the cost of a significant procedure or medical visit was associated with packaged ancillaries. For the full packaging option, Table 5.17 shows, by

	Window of Time				
	One Day	Three Days		Seven Days	
	Count	Count	Pct Decrease	Count	Pct Decrease
Significant Procedure Claims	1,943,837	1,934,966	0.46	1,915,823	1.44
Medical Claims	2,187,170	2,178,052	0.42	2,154,742	1.48
Ancillary Revenue Trailers	7,281,731	7,061,882	3.02	6,797,688	6.65

Table 5.16 Decrease in Number of Claims for Three Day and Seven Day Window of Time

type of APG, the percentage of the APG cost associated with packaged with packaged ancillaries for the three different windows of time. As can be seen from Table 5.17, there was only a very small increase in the percentage of APG cost from packaged ancillaries as the window of time was expanded.

APG Systems 3, 12 and 13 use a same day, three day and seven day window of time, respectively, with cost based weights, full ancillary packaging, 1 percent outliers, 50 percent multiple significant procedure discounting and no ancillary discounting. The R^2 for all three APG systems is virtually the same. Thus, there is no substantial impact on R^2 as a result of expanding the window of time of ancillary packaging.

	Window of Time		
	One Day	Three Days	Seven Days
Significant Procedure Claims	9.24	9.48	9.84
Medical Claims	31.34	31.60	31.89
Significant Procedure and Medical Claims Combined	15.44	15.83	16.32

Table 5.17 Percent of APG Cost Derived from Packaged Ancillaries for the Three Different Windows of Time

The results for normalized mean absolute difference and mean percent absolute difference in Table 5.13 and Table 5.14 closely parallel the results for R^2 except that the magnitude of the differences observed were not as great. For example, APG Systems 7, 3 and 8 have an R^2 for medical claims of 0.264, 0.588 and 0.726 respectively. The corresponding normalized mean absolute differences are 60.31, 56.41 and 50.01 and the mean percent absolute differences are 169.24, 166.79 and 161.77, respectively. Thus, while the R^2 for APG Systems 7 and 8 differs by 175 percent, the normalized mean absolute difference differs by 15.6 percent and the mean percent absolute difference differs by only 4.4 percent. Thus, normalized mean absolute difference and mean percent absolute difference are much less sensitive than R^2 to changes in the components of the APG system.

Hospital APG Impact Simulation

Medicare payment for hospital outpatient services is based on a complex and confusing collection of payment methods. The current Medicare system pays hospital outpatient services under a number of different methods including fee schedules, blended payment methods and cost based payments. It was beyond the scope of this project to compute actual historical Medicare outpatient payments and compare actual payments to APG based payments. Thus, the results of the 13 APG impact simulations do not precisely reflect the actual impact on hospitals because the actual payments to hospitals based on the current complex and confusing system were not calculated. In addition, for

purposes of the impact simulation, APG payment rates were not calculated based on the current level of Medicare program expenditures, which is less than hospital costs, but instead, were calculated based on what total program expenditures would be under a pure cost based system. Thus, for purposes of calculating and comparing the impact of the 13 different APG impact simulations, hospital payments under each specific APG system were computed with the constraint that in the aggregate, Medicare total expenditures under any of the APG systems was equal to total hospital costs. The most basic of the 13 formulations of an APG system was selected as the reference APG system and the *relative* APG impact was computed by comparing cost based APG payments under each of the other APG systems to the reference APG system. The relative APG impact was computed for different categories of hospitals and was used to evaluate each component of the APG system (e.g., the extent of outlier payments) in terms of its relative impact across different categories of hospitals. Hospital characteristics were identified by linking the provider number on each claim to the FY1993 PPS Payment Impact File. A description of the FY 1993 PPS Payment Impact File is contained in Appendix P.

Hospitals were categorized into 67 categories. The categories were not mutually exclusive and the same hospital could appear in multiple categories. The hospital categories replicated the hospital categories used by HCFA to display the inpatient PPS impact results. All information necessary to create the hospital categories was available in the FY 1993 PPS Payment Impact File, except hospital ownership. Hospital ownership was obtained using a separate file provided by HCFA. Appendix Q contains the definition of each hospital category.

The hospital categorization was done in two different ways, one based on geographic location and the other on payment categories. In the geographic location section, the metropolitan statistical area (MSA), the region of the country and the urban/rural status is based on the *actual* location of the hospital. Since these hospital location characteristics affect the inpatient PPS payment levels, the Executive Office of Management and Budget reclassifies the urban/rural designation, as well as the MSA and geographic region. In the payment categories section the MSA, the region of the country and the urban/rural status was based on the *reclassified* location of the hospital used in the inpatient PPS.

Table 5.18 and Table 5.19 contain summary statistics for the geographic location and payment categories, respectively. The summary statistics for each hospital category are the number of hospitals in the FY 1993 PPS Payment Impact File, the number of hospitals in the analysis database, the number of claims in the analysis database, aggregate charges in the analysis database and aggregate cost in the analysis database. The FY 1993 PPS Payment Impact File contained 5,491 hospitals. Only hospitals covered by the inpatient PPS were included in the PPS Payment Impact File. The analysis database included 5,118 (92.3 percent) of the PPS hospitals. In addition, the analysis database contained data from 356 hospitals that were not covered by the inpatient PPS (e.g., psychiatric hospitals). The non PPS hospitals had very few claims per hospital in the analysis database. For PPS hospitals there was

an average of 2,222 claims per hospital in the analysis database, but for non PPS hospitals there was only an average of 60.2 claims per hospital. There were also 16 hospitals that were PPS hospitals that were not in the 1993 PPS Payment Impact File. Since the data was from 1992, these are probably hospitals that closed or merged with other hospitals in 1993. In total, there were 5,490 hospitals in the analysis database.

Table 5.20 and Table 5.21 contain for each hospital category the impact of each of the 13 APG systems. APG System 6 represents the most basic version of an APG system. APG System 6 uses cost based relative weights, limited packaging, no outliers, no ancillary discounting and a same day window of time. The impact of an APG system APG system was measured by taking the aggregate APG payment to hospitals in the hospital category under the APG system, subtracting the aggregate APG payments to hospitals in the hospital category under APG System 6 and dividing the difference by the aggregate APG payments to hospitals in the hospital category under APG System 6. The formula for computing the impact is contained in Appendix N. The result is the percent difference between hospital payments under the APG system being evaluated and hospital payments under APG System 6. A impact of +2.0 would indicate that the hospitals in the hospital category would receive two percent more in aggregate payments under the APG system being evaluated than the hospitals would have under the basic APG system (i.e., APG System 6). The impact measures how the aggregate payments to hospitals in each hospital category would change as the basic APG system (i.e., APG System 6) is expanded (e.g., more extensive ancillary packaging, the addition of outlier payments, etc.). Thus, the impact provides a means of evaluating each component of the APG system in terms of its effect on aggregate APG based payments to different categories of hospitals. It does *not* provide a measure of the change in actual payments that hospitals would receive under an APG payment system.

The discussion of the impact is based on Table 5.20 and Table 5.21. APG System 1 adds one percent outlier payments to the basic APG system (i.e., APG System 6) and APG System 9 adds three percent outlier payments. There was relatively little impact across categories of hospitals as a result of adding outlier payments to the APG payment APG system. In general, the impact with outlier payments added was within one percent of the basic APG system.

APG System 7 adds full packaging to the basic APG system. The addition of full packaging does tend to have a substantial impact across categories of hospitals. As a result of the addition of full packaging to the basic APG system, teaching hospitals with a resident to bed ratio greater than 0.25 have a 3.42 percent increase relative to the basic APG system. Urban hospitals over 500 beds, urban disproportionate share teaching hospitals, rural Medicare dependent hospitals, small rural hospitals and government hospitals experienced an increase between one and two percent as a result of adding full packaging to the basic APG system. There were no hospital categories that experienced a substantial decrease, except for proprietary hospitals, which experienced a 1.21 percent decrease.

Hospital Category	Hosp Cnt		Claim Count	Tot Chg ($Mil)	Tot Cost ($Mil)
	In Prov File	In Data			
LOCATION:					
URBAN HOSPITALS	2,944	2,733	8,190,402	2,961.86	1,597.13
LARGE URBAN AREAS	1,517	1,393	4,125,328	1,585.45	861.90
OTHER URBAN AREAS	1,427	1,340	4,065,074	1,376.41	735.22
RURAL AREAS	2,547	2,385	3,181,641	763.60	411.50
BED SIZE (URBAN):					
0-99 BEDS	687	594	654,720	205.71	114.21
100-199 BEDS	883	835	1,780,271	670.26	353.02
200-299 BEDS	628	597	2,086,194	796.22	422.47
300-499 BEDS	550	526	2,374,139	867.10	460.22
500 OR MORE BEDS	196	181	1,295,078	422.57	247.21
BED SIZE (RURAL):					
0-49 BEDS	1,268	1,155	765,312	118.32	71.38
50-99 BEDS	776	742	1,048,716	237.24	129.25
100-149 BEDS	263	253	547,946	159.36	81.41
150-199 BEDS	124	121	368,176	107.07	55.66
200 OR MORE BEDS	116	114	451,491	141.61	73.80
URBAN BY CENSUS DIV:					
NEW ENGLAND	169	159	652,416	181.21	108.42
MIDDLE ATLANTIC	462	429	1,629,629	454.19	268.10
SOUTH ATLANTIC	461	430	1,353,777	564.13	289.42
EAST NORTH CENTRAL	468	452	1,726,833	567.13	316.44
EAST SOUTH CENTRAL	168	163	412,448	164.36	77.10
WEST NORTH CENTRAL	197	194	540,121	179.49	101.23
WEST SOUTH CENTRAL	356	330	555,283	285.25	145.34
MOUNTAIN	113	106	35,0432	131.01	71.37
PACIFIC	501	432	8,93409	426.44	215.59
PUERTO RICO	49	38	7,6054	8.64	4.11
RURAL BY CENSUS DIV:					
NEW ENGLAND	57	57	141,401	30.88	17.17
MIDDLE ATLANTIC	99	92	310,469	58.35	29.91
SOUTH ATLANTIC	345	327	573,614	177.15	88.87
EAST NORTH CENTRAL	338	333	604,922	134.84	74.95
EAST SOUTH CENTRAL	300	281	318,787	77.61	37.05
WEST NORTH CENTRAL	578	541	501,092	105.07	61.89
WEST SOUTH CENTRAL	403	373	324,295	85.20	45.62
MOUNTAIN	258	233	210,708	44.85	27.51
PACIFIC	163	144	189,388	49.09	28.24
PUERTO RICO	6	4	6,965	0.55	0.28

Table 5.18 Summary Statistics by Hospital Categories by Geographic Location

Hospital Category	Hosp Cnt		Claim Count	Tot Chg ($Mil)	Tot Cost ($Mil)
	In Prov File	In Data			
PAYMENT LOCATION:					
URBAN HOSPITALS	3,163	2,949	8,579,649	3,065.82	1,651.21
LARGE URBAN AREAS	1,671	1,544	4,604,685	1,740.90	946.80
OTHER URBAN AREAS	1,492	1,405	3974964	1324.92	704.41
RURAL AREAS	2,328	2,169	2,792,394	659.64	357.41
TEACHING STATUS:					
NON-TEACHING	4,429	4,133	7,014,343	2,327.93	1,217.15
RESIDENT TO BED RATIO <.25	829	782	3,070,693	1,069.25	583.71
RESIDENT TO BED RATIO >=.25	233	203	1,287,007	328.28	207.77
DISPROPORTIONATE SHARE HOSPITALS:					
NON-DSH	3,807	3,556	7,067,733	2,274.80	1,237.22
URBAN DSH:					
100 BEDS OR MORE	1,180	1,111	37,75,674	1,311.78	702.51
FEWER THAN 100 BEDS	99	81	55,158	14.19	7.23
RURAL DSH:					
SOLE COMMUNITY (SCH)	101	101	101,783	24.47	12.59
REFERRAL CENTERS (RRC)	46	45	127,531	40.51	19.89
OTHER RURAL DSH HOSP:					
100 BEDS OR MORE	68	62	111,358	34.08	16.24
FEWER THAN 100 BEDS	190	162	132,806	25.63	12.93
URBAN TEACHING AND DSH:					
BOTH TEACHING AND DSH	574	529	2,366,113	720.01	409.30
TEACHING AND NO DSH	437	405	1,810,505	634.44	358.53
NO TEACHING AND DSH	705	663	1,464,719	605.95	300.44
NO TEACHING AND NO DSH	1,447	1,352	2,938,312	1,105.42	582.93
RURAL HOSPITAL TYPES:					
NONSPECIAL STATUS HOSPITALS	1,047	970	1,153,748	257.38	137.17
RURAL REFERRAL CENTER(RRC)	180	178	556,262	173.19	91.54
SOLE COMMUNITY HOSPITAL (SCH)	563	552	585,803	128.94	72.26
SCH AND RRC	46	46	151,666	42.07	23.17
MEDICARE DEPENDENT SMALL RURAL HOSPITAL	444	423	344,915	58.06	33.27
TYPE OF OWNERSHIP:					
VOLUNTARY	3,316	3,043	8,373,972	2,722.24	1,493.79
PROPRIETARY	730	693	1,011,257	501.05	223.27
GOVERNMENT	1,445	1,382	1,986,814	502.17	291.57

Table 5.19 Summary Statistics by Hospital Categories by Payment Categories

Hospital Categories	APG System 1	2	3	4	5	6	7	8	9	10	11	12	13
LOCATION:													
URBAN HOSPITALS	0.00	-0.25	-0.07	-0.34	-0.05	0.00	-0.08	0.01	0.12	-0.01	-0.07	-0.16	-0.68
LARGE URBAN AREAS	0.13	-0.68	0.19	-0.62	0.23	0.00	0.04	0.55	0.56	0.11	0.18	0.11	-0.42
OTHER URBAN AREAS	-0.13	0.23	-0.35	-0.03	-0.36	0.00	-0.21	-0.59	-0.38	-0.13	-0.36	-0.47	-0.97
RURAL AREAS	-0.07	1.11	0.17	1.42	0.10	0.00	0.26	-0.17	-0.51	-0.03	0.20	-0.20	-0.82
BED SIZE (URBAN):													
0-99 BEDS	0.55	0.87	0.43	0.71	0.41	0.00	-0.13	1.27	1.38	0.60	0.47	0.12	-0.41
100-199 BEDS	0.05	0.36	-0.31	-0.07	-0.29	0.00	-0.39	0.27	0.74	0.03	-0.31	-0.44	-1.03
200-299 BEDS	0.06	0.76	-0.58	-0.02	-0.55	0.00	-0.65	-0.52	0.15	0.05	-0.59	-0.68	-1.11
300-499 BEDS	-0.17	-0.36	-0.34	-0.57	-0.33	0.00	-0.18	-0.63	-0.47	-0.18	-0.35	-0.34	-0.79
500 OR MORE BEDS	-0.06	-3.02	1.42	-1.23	1.43	0.00	1.51	1.25	-0.18	-0.07	1.40	1.28	0.56
BED SIZE (RURAL):													
0-49 BEDS	0.50	0.87	2.77	3.65	2.59	0.00	2.38	2.85	0.14	0.51	2.81	2.31	1.75
50-99 BEDS	0.03	1.29	0.34	1.72	0.25	0.00	0.34	0.21	-0.27	0.05	0.38	-0.17	-0.91
100-149 BEDS	-0.25	1.43	-0.66	0.95	-0.72	0.00	-0.38	-1.12	-0.78	-0.20	-0.64	-1.00	-1.65
150-199 BEDS	-0.30	0.88	-0.50	0.65	-0.53	0.00	-0.19	-1.30	-1.09	-0.25	-0.48	-0.65	-1.18
200 OR MORE BEDS	-0.33	0.86	-0.97	0.10	-0.96	0.00	-0.64	-1.48	-0.73	-0.28	-0.95	-1.24	-1.71
URBAN BY CENSUS DIV:													
NEW ENGLAND	-0.59	-2.36	0.25	-1.44	0.29	0.00	0.83	-0.24	-0.87	-0.59	0.25	-0.30	-1.50
MIDDLE ATLANTIC	-0.23	-0.01	0.36	0.66	0.37	0.00	0.60	0.63	0.36	-0.18	0.37	-0.12	-1.83
SOUTH ATLANTIC	0.18	0.21	-0.76	-0.90	-0.75	0.00	-0.98	-0.47	0.38	0.15	-0.77	-0.72	-0.83
EAST NORTH CENTRAL	-0.28	0.16	-0.57	-0.22	-0.56	0.00	-0.30	-0.81	-0.40	-0.31	-0.57	-0.78	-1.50
EAST SOUTH CENTRAL	0.24	0.38	-0.57	-0.55	-0.59	0.00	-0.83	-0.67	0.08	0.22	-0.60	-0.63	-0.81
WEST NORTH CENTRAL	0.22	-0.18	0.10	-0.30	0.17	0.00	-0.12	-0.08	-0.04	0.18	0.08	0.13	0.04
WEST SOUTH CENTRAL	0.68	0.36	-0.41	-0.88	-0.48	0.00	-1.16	0.57	1.64	0.58	-0.43	-0.12	0.12
MOUNTAIN	0.38	-2.35	1.81	-0.58	1.73	0.00	1.46	2.13	0.39	0.37	1.79	1.91	1.66
PACIFIC	0.10	-0.43	0.51	0.03	0.60	0.00	0.46	0.49	-0.06	0.15	0.50	0.71	0.89
PUERTO RICO	-0.93	-4.28	2.07	-0.14	2.16	0.00	3.03	0.34	-2.51	-0.87	2.14	2.46	1.83
RURAL BY CENSUS DIV:													
NEW ENGLAND	-0.51	1.57	0.02	2.11	0.02	0.00	0.56	-0.44	-0.91	-0.37	0.08	-0.41	-1.15
MIDDLE ATLANTIC	-0.70	1.03	0.16	1.98	0.09	0.00	0.89	-1.32	-2.11	-0.63	0.15	-0.87	-2.86
SOUTH ATLANTIC	0.15	1.06	-1.00	-0.23	-0.97	0.00	-1.18	-0.91	-0.03	0.14	-0.97	-1.19	-1.51
EAST NORTH CENTRAL	-0.21	2.26	-0.82	1.53	-0.88	0.00	-0.59	-1.30	-0.69	-0.21	-0.79	-1.37	-2.33
EAST SOUTH CENTRAL	-0.27	0.80	0.00	1.23	-0.08	0.00	0.31	-0.76	-1.10	-0.25	0.02	-0.36	-0.76
WEST NORTH CENTRAL	0.18	0.67	1.43	2.19	1.36	0.00	1.34	1.23	-0.15	0.27	1.46	1.02	0.45
WEST SOUTH CENTRAL	0.26	0.17	0.97	1.12	0.76	0.00	0.72	1.30	0.49	0.24	0.99	0.76	0.52
MOUNTAIN	0.07	1.12	1.82	3.22	1.66	0.00	1.84	1.48	-0.44	0.15	1.86	1.65	1.61
PACIFIC	-0.16	0.76	1.10	2.25	1.00	0.00	1.31	0.63	-0.85	-0.07	1.14	1.13	0.90
PUERTO RICO	-0.96	1.41	2.35	5.64	2.52	0.00	3.39	0.51	-2.86	-0.73	2.44	0.16	-5.43

Table 5.20 Impact by Hospital Categories by Geographic Location Across APG Systems

Hospital Category	APG Systems 1	2	3	4	5	6	7	8	9	10	11	12	13
PAYMENT LOCATION:													
URBAN HOSPITALS	0.00	-0.18	-0.10	-0.31	-0.09	0.00	-0.11	-0.03	0.10	-0.01	-0.11	-0.21	-0.74
LARGE URBAN AREAS	0.07	-0.55	0.08	-0.55	0.12	0.00	-0.01	0.38	0.42	0.05	0.08	-0.01	-0.55
OTHER URBAN AREAS	-0.09	0.29	-0.33	0.00	-0.35	0.00	-0.23	-0.55	-0.32	-0.09	-0.34	-0.47	-0.98
RURAL AREAS	-0.06	1.00	0.36	1.53	0.28	0.00	0.45	0.00	-0.52	-0.01	0.39	-0.01	-0.57
TEACHING STATUS:													
NON-TEACHING	0.05	1.28	-0.55	0.56	-0.55	0.00	-0.61	-0.48	0.04	0.05	-0.54	-0.72	-1.14
RESIDENT TO BED RATIO < 25	-0.12	0.06	-0.18	-0.04	-0.18	0.00	-0.05	-0.30	-0.14	-0.11	-0.17	-0.24	-0.80
RESIDENT TO BED RATIO >= 25	-0.05	-6.95	3.33	-2.84	3.37	0.00	3.42	3.27	0.05	-0.08	3.31	3.02	1.91
DISPROP SHARE HOSPITALS:													
NON-DSH	-0.05	0.97	-0.36	0.58	-0.36	0.00	-0.32	-0.34	-0.01	-0.03	-0.35	-0.55	-1.08
URBAN DSH:													
100 BEDS OR MORE	0.06	-1.59	0.56	-0.96	0.57	0.00	0.51	0.56	0.03	0.03	0.55	0.48	-0.08
FEWER THAN 100 BEDS	0.25	0.29	0.08	0.17	0.08	0.00	-0.16	-0.15	-0.53	0.24	0.12	0.07	-0.05
RURAL DSH:													
SOLE COMMUNITY (SCH)	0.08	-0.08	0.02	0.01	-0.12	0.00	-0.04	0.29	0.09	0.02	0.05	-0.13	-0.29
REFERRAL CENTERS (RRC)	-0.23	-0.96	-0.33	-1.00	-0.25	0.00	-0.08	-0.65	-0.56	-0.19	-0.32	-0.51	-0.96
OTHER RURAL DSH HOSP:													
100 BEDS OR MORE	-0.37	0.27	-0.68	-0.05	-0.77	0.00	-0.30	-1.17	-0.75	-0.30	-0.64	-1.06	-1.45
FEWER THAN 100 BEDS	-0.06	0.10	1.25	1.83	1.12	0.00	1.33	0.73	-0.95	-0.08	1.28	1.04	0.85
URBAN TEACHING AND DSH:													
BOTH TEACHING AND DSH	0.09	-3.26	1.62	-1.38	1.62	0.00	1.57	1.45	-0.11	0.05	1.61	1.49	0.71
TEACHING AND NO DSH	-0.28	-0.14	-0.23	-0.13	-0.22	0.00	0.05	-0.20	0.04	-0.25	-0.22	-0.35	-0.98
NO TEACHING AND DSH	0.03	0.86	-0.97	-0.32	-0.95	0.00	-1.03	-0.73	0.22	-0.01	-0.99	-0.98	-1.22
NO TEACHING AND NO DSH	0.10	1.54	-0.85	0.38	-0.83	0.00	-0.98	-0.65	0.23	0.10	-0.85	-0.98	-1.41
RURAL HOSPITAL TYPES:													
NONSPECIAL STATUS HOSPITALS	0.00	1.09	0.60	1.86	0.52	0.00	0.64	0.31	-0.43	0.03	0.63	0.09	-0.58
RURAL REFERRAL CENTER (RRC)	-0.43	0.83	-0.67	0.53	-0.70	0.00	-0.24	-1.39	-1.06	-0.36	-0.65	-0.90	-1.37
SOLE COMMUNITY HOSPITAL (SCH)	0.12	1.29	0.77	2.12	0.66	0.00	0.71	0.74	-0.16	0.16	0.81	0.47	-0.03
SCH AND RRC	-0.01	0.46	-0.10	0.34	-0.11	0.00	-0.08	-0.95	-0.95	0.06	-0.08	-0.13	-0.33
MEDICARE DEPENDENT SMALL RURAL HOSPITAL (MDH)	0.39	0.94	1.93	2.84	1.80	0.00	1.60	2.05	0.24	0.40	1.96	1.36	0.53
TYPE OF OWNERSHIP:													
VOLUNTARY	-0.16	0.35	-0.27	0.18	-0.27	0.00	-0.12	-0.36	-0.19	-0.14	-0.27	-0.45	-1.07
PROPRIETARY	0.40	0.82	-0.75	-0.49	-0.71	0.00	-1.21	-0.14	0.82	0.32	-0.77	-0.69	-0.74
GOVERNMENT	0.43	-2.23	1.84	-0.46	1.82	0.00	1.45	1.82	0.32	0.41	1.84	1.67	1.20

Table 5.21 Impact by Hospital Categories by Payment Categories Across APG Systems

APG Systems 3 and 8 add one percent and three percent outlier payments to the full packaging option in APG System 7, respectively. The addition of outliers to the full packaging option of APG System 7 does not substantially change the results, except that with full packaging and three percent outliers, rural hospitals over 100 beds do experience a more substantial decrease.

The addition of ancillary discounting (APG System 11) or the addition of an expanded window of service (APG Systems 12 and 13) to the full packaging APG system with one percent outliers (APG System 3) does not substantially change the results across categories of hospitals.

APG Systems 2 and 4 use charge based relative weights whereas all other APG systems use cost based relative weights. The change to charge based relative weights has a substantial impact across hospital categories. APG Systems 3 and 4 are the same except that APG System 3 uses cost based relative weights and APG System 4 uses charge based relative weights. For example, for teaching hospitals with a resident to bed ratio greater than 0.25, APG System 3 would result in an increase relative to the basic APG system, of 3.33 percent, while APG System 4 would result in a decrease of 2.84 percent. The cause of this relative APG impact is the low cost-to-charge ratios for ancillary departments. Hospitals that have the majority of their outpatient services as ancillary services would experience a decrease using cost based relative weights, since cost based ancillary APG relative weights are proportionately lower. Conversely, hospitals that have the majority of their services as direct patient care services (e.g., emergency room visits) would have an increase using cost based relative weights, since cost based significant procedure and medical APG relative weights are proportionately higher. To illustrate this impact, hospitals were categorized based on the percent of patients who only received ancillary services (i.e., no significant procedure or medical visit). APG System 3 and APG System 4 are the same, except that APG System 3 uses cost based relative weights and APG System 4 uses charge based relative weights. The difference in APG payment under APG System 3 and APG System 4 was computed and divided by the APG payment under APG System 4. The result is the percent difference in APG payment due to cost based relative weights as opposed to charge based relative weights. Table 5.22 shows the results across hospitals categorized by the percent of ancillary only claims.

In Table 5.22, the 269 hospitals having less than 5 percent of their claims with only ancillaries had an increase equal to 6.921 percent by using cost based relative weights instead of charge based relative weights. Conversely, the 72 hospitals having 95 percent or more of their claims with only ancillaries had a decrease equal to 10.948 percent by using cost based relative weights instead of charge based relative weights.

In summary, the alternative formulations of APG systems did not result in substantial differences in impact across different categories of hospitals. The only components of the APG system that caused any substantial variations in impact across different categories of hospitals were the selection of charge versus cost based relative weights and the extent of ancillary packaging.

Percent Ancillary Only	Count Hosp	Percent Diff APG Impact
0-5	269	6.921
5-10	50	11.776
10-15	62	14.121
15-20	47	9.556
20-25	65	8.580
25-30	82	6.679
30-35	119	3.845
35-40	130	2.008
40-45	184	1.807
45-50	268	1.384
50-55	361	0.569
55-60	398	0.033
60-65	467	-0.426
65-70	574	-1.146
70-75	592	-1.759
75-80	666	-2.775
80-85	578	-4.043
85-90	340	-5.609
90-95	166	-7.439
95-100	72	-10.948

Table 5.22 Percent Difference in Impact Between APG System 3 and APG System 4 by Percent of Hospital Claims that are Ancillary Only

Discussion and Recommendations

The statistical performance of the APGs, in terms of R^2, normalized mean absolute difference and mean percent absolute difference was evaluated for 13 different APG systems. The statistical results provide a measure of the extent to which simulated APG payments for a patient correspond to the historical cost for the patient. In general, the statistical performance of the APGs is better than the statistical performance of the inpatient DRGs. The evaluation of the 13 different APG systems resulted in the following conclusions:

- There is virtually no difference in statistical results for APG relative weights derived from charges or cost.
- The extent of ancillary packaging does affect the statistical performance of the APGs. The statistical results for the simple packaging and full packaging are virtually identical. In comparison to limited packaging, full packaging has minimal impact on statistical performance for significant procedure claims, but causes a modest decrease in statistical performance for medical claims.

- The APG outlier policy has a significant impact on the statistical performance of the APGs. Failure to have any outlier policy causes a large reduction in statistical performance, especially for medical claims. An outlier policy of having one percent of total APG payments associated with outliers results in a large improvement in statistical performance. A three percent outlier policy further improves statistical performance but results in a substantial increase in the number of claims with outlier payments.
- The addition of a 20 percent discount for repeated ancillaries within the same APG has no substantial impact on statistical performance.
- Expanding the ancillary packaging of window of service for significant procedure and medical claims beyond the same day has no substantial impact on statistical performance.
- Across the 13 APG systems, the only factors that have a substantial impact by category of hospital are the extent of ancillary packaging and the basis of the relative weights.

Based on the above results, the recommended APG system is as follows:

- Although the charge and cost based APG relative weights were highly correlated and there was virtually no difference in statistical performance between the charge and cost based APG relative weights, the use of cost based relative weights is recommended. Since the cost-to-charge ratio for ancillary departments tends to be lower than other departments, the charge based APG relative weights for ancillary services tend to be higher than the cost based APG relative weights. This would result in proportionately higher APG payments for ancillary services with charge based relative weights than with cost based relative weights. In particular, it would result in an increase for hospitals that deliver ancillaries as their primary outpatient service. As a result of this bias, cost based relative weights are recommended. This bias is the source of the impact differences across hospital categories that would result from using charge based relative weights.
- Ancillary packaging provides the financial incentives for hospital outpatient departments to utilize ancillary services efficiently. In order to provide such incentives, the full ancillary packaging option is recommended. There was a moderate decrease in statistical performance for medical claims associated with the full packaging option, and there was some impact across hospital categories as a result of full ancillary packaging.
- Failure to have an outlier policy would result in a significant decrease in statistical performance of the APGs. An outlier policy in which one percent of total payments are associated with outliers is recommended.
- While the discounting of repeated ancillary services did not affect statistical performance, the discounting of high volume, low cost ancillary services in the same APG would add complexity to the system with

relatively few benefits. Thus, discounting of repeated ancillary services is not recommended.

- While it would be desirable to have a wide window of time for ancillary packaging, in order to avoid the incentive to have ancillaries provided on a different day, the current UB-92 does not identify the provider who ordered the ancillary service. Thus, the packaging of ancillaries ordered by a provider and delivered on a different day would impose a significant administrative burden because there is no automated way to identify such ancillaries within the Medicare billing system. It is recommended that the initial implementation of the APGs should have a same day window of time for ancillary packaging. If a wider window of time for ancillary packaging is desired, the identification of the provider who ordered the ancillary must be added to the claim.

In summary, the recommended APG system is APG System 3, which consists of cost based relative weights, full ancillary packaging, a one percent outlier policy, fifty percent discounting of each additional significant procedure, no repeat ancillary discounting and a same day window of time for ancillary packaging. The statistical performance of this APG system exceeded the statistical performance of the current inpatient DRGs. Relative to the basic APG system, APG System 3 does impact some categories of hospitals. The magnitude of the impact to any hospital category is always less than four percent. The impact on some hospital categories due to APG System 3 is largely the result of the full ancillary packaging.

CHAPTER 6

Implementation Issues

Implementation Issues

The APG system provides the framework for a hospital based outpatient prospective payment system. However, there are a series of additional issues that must be addressed as part of the implementation of an APG based prospective payment system:

Volume of Visits

In any visit based system, hospitals can increase revenue by increasing the number of visits. Under the existing Medicare outpatient payment system an increase in visits will increase hospital revenue but not necessarily hospital profits. A change to an APG based PPS may create greater incentives to increase visits for certain services. Thus, some means of monitoring and controlling the number of visits should be implemented.

Upcoding and Fragmentation of Procedure Codes

Although the aggregation of codes into the APGs minimizes the opportunities for upcoding, hospital coding practices will need to be monitored. Procedure code fragmentation occurs when a single procedure is reported using multiple procedure codes. Currently, the Outpatient Code Editor is applied by Medicare to outpatient claims. The Outpatient Code Editor should be expanded in scope to address issues such as procedure code fragmentation.

Identification of Visits

Since APGs are a visit based payment system, it is essential that visits can be unambiguously identified from the claim form. Batch bills, in which

the dates of service span more than one day, present difficulties for the identification of individual visits. Clear rules for the reporting of the dates of service, the units field on the revenue trailers and the submission of batch bills need to be established. The result of these rules should be the ability to uniquely identify an individual visit and the services rendered during that visit.

Shift of Ancillaries to Nonhospital Settings as a Result of Ancillary Packaging

If the implementation of an APG based PPS includes the full packaging of ancillary services, hospitals will have the financial incentive not to provide the ancillary services directly but to send the patient to a nonhospital setting for the ancillary tests. The nonhospital facility could then bill Medicare separately for the ancillary tests. Thus, ancillaries ordered by hospital outpatient departments but delivered by nonhospital settings must be able to be identified within the claims processing system. In order to expand the window of services for ancillary packaging and to include within the ancillary packaging, all ancillaries ordered by the hospital outpatient department, the claim processing system must identify the provider that ordered an ancillary service.

Payment of Ancillaries Ordered Outside the Hospital

A large volume of the services provided by the ancillary department of hospitals are ordered by private physicians or other nonhospital based providers. If hospitals are paid on an APG basis for ancillaries ordered outside the hospital, and nonhospital facilities are paid on a different basis, then there will be a payment differential for the same ancillary depending on whether the ancillary service is delivered by a hospital or a nonhospital facility. If hospital ancillary departments are paid less than nonhospital facilities, then hospitals will be at a competitive disadvantage. A negative price differential could cause a shift of ancillary services out of the hospital.

Applicability

An outpatient PPS need not be limited to hospital outpatient departments but could also include entities that provide similar services. For example, ambulatory surgery centers and free-standing radiology centers that provide services similar to hospital outpatient departments could also be included in an outpatient PPS.

Consistency with Inpatient Payment Levels

The increase in hospital based ambulatory surgery was, in part, the result of the financial incentives in the Medicare payment system. Since inpatient surgery was paid at the fixed DRG rate and hospital based ambulatory surgery was essentially paid at cost, there was a financial incentive to shift patients to the ambulatory setting where there were no cost controls. If ambulatory surgery is paid at a fixed price, then, depending on the payment rate for surgery performed on an inpatient basis, there may be a financial incentive to perform surgery on an

inpatient basis. The inpatient and outpatient payment rates for the same surgical procedure need to be established to provide the proper financial incentives.

Computation of Prospective APG Payment Rates

Historical charges or cost can be used to compute an initial set of APG relative weights. If the historical charges or cost for some procedures are artificially high, then the APG relative weights would be disproportionately high. Consideration needs to be given to reevaluating some of the APG relative weights based on actual resource use instead of historical cost.

Hospital Specific Payment Adjustments

The inpatient PPS adjusts the DRG payment levels for hospitals based on hospital specific factors such as disproportionate share and teaching status. The APG simulations included adjustments for labor costs and outliers. An evaluation of whether additional adjustments are necessary in an APG based outpatient PPS needs to be performed.

Beneficiary Coinsurance Payments

Currently, Medicare beneficiary outpatient coinsurance payments are based on hospital charges. Since Medicare pays for hospital outpatient care in part based on cost and cost is significantly lower than charges, the beneficiary is actually paying a much larger percentage of outpatient cost than their coinsurance percentage (e.g., if charges are twice as high as cost, then a 20 percent coinsurance rate would actually be equivalent to a 40 percent coinsurance rate). Since the APG rates would be based on cost, the implementation of an APG based outpatient PPS would significantly lower beneficiary coinsurance payments. If Medicare did not increase payments to hospitals to compensate for the reduced beneficiary payments, then hospitals would suffer a significant revenue reduction. The implementation of an outpatient PPS must include a method for dealing with the beneficiary coinsurance issue.

APG Update Process

The APGs will need to be reviewed and updated on an annual basis to reflect changes in technology and practice patterns as well as the annual changes in the procedure and diagnosis codes.

CHAPTER 7

Conclusions

Conclusions

A visit based APG prospective payment system can provide an effective system for the payment of the facility component of hospital based outpatient care. The APGs form a manageable, clinically meaningful set of patient classes that relate the attributes of patients to the resources, demands and associated costs experienced by a hospital outpatient department. In order to insure that the APGs could be readily implemented as the basis of a Medicare outpatient PPS, Version 2.0 of the APGs was developed in close collaboration with the policy, operations and research staff of the Health Care Financing Administration. The components of the APG system can be configured to achieve specific policy objectives and to provide financial incentives for hospitals to provide efficient care. Based on the statistical performance and relative APG impact across the alternative formulations of the components of an APG system, an APG system with cost based weights, full ancillary packaging, one percent of payments derived from outlier payments, 50 percent multiple significant procedure discounting, no repeat ancillary discounting and a same day window of time is recommended. Remaining implementation issues can be readily resolved and an APG based outpatient PPS can be implemented within a short time frame. In an era of health care cost containment, a cost based payment system for hospital outpatient care is an anachronism and must be replaced. An APG based outpatient prospective payment system can be a practical and effective basis for the reform of the Medicare cost based outpatient payment system.

APPENDIX A

Summary of Development of Version 1.0 of the APGs

Appendix A reviews the characteristics of a classification system for ambulatory patients, describes the development of Version 1.0 of the Ambulatory Patients Groups (APGs) and presents the results of simulating the use of Version 1.0 of the APGs in a prospective payment system.

Patient Classification System Characteristics

Fundamental to the design of any Prospective Payment System (PPS) for ambulatory care is the selection of the basic unit of payment. The Medicare inpatient PPS uses the hospital admission as the basic unit of payment. The basic unit for ambulatory care is the visit, which represents a contact between the patient and a health care professional. The visit could be for a procedure, a medical evaluation, or an ancillary service such as a chest x-ray. For each type of visit a prospective price could be established that includes all routine services (e.g., blood tests, chest x-rays, etc.) associated with the visit. If the cost of the routine services rendered during a visit were included in the payment for the visit, hospitals would have the financial incentive to control the amount of services rendered.

An ambulatory patient classification system serves the same function as DRGs in the inpatient PPS. The patient classification system provides the basic product definition for the ambulatory setting and will have important secondary effects. For example, DRGs have brought about fundamental changes in management, communications, cost accounting and planning within hospitals. These changes have resulted in improved efficiency in the delivery of inpatient care. The benefits to hospital management that resulted from the adoption of DRGs would also be expected to occur in the ambulatory setting. Thus, the selection of an appropriate patient classification system is critical to the success of an ambulatory PPS and the achievement of the associated secondary benefits. An ambulatory patient classification system should have the following characteristics.

Comprehensiveness

The patient classification system must be able to describe every type of patient seen in an ambulatory setting. This includes medical patients, patients undergoing a procedure and patients who receive ancillary services only.

Administrative Simplicity

The patient classification system should be administratively straightforward to implement. The number of patient classes should be kept to a reasonable number. A patient classification system containing relatively few patient classes (e.g., fewer than the number of DRGs) will be more easily understood by providers and will ease the administrative burden on both facilities and payors. In addition, the data used to define the patient classes should be compatible with existing billing, data collection, coding, storage and processing practices. Such compatibility will decrease implementation costs, data errors and other administrative problems.

Homogeneous Resource Use

The amount and type of resources (e.g., operating room time, medical surgical supplies, etc.) used to treat patients in each patient class should be homogeneous. If resources used vary widely within a patient class, it would be difficult to develop equitable payment rates. If a facility treated a disproportionate share of either the expensive or inexpensive cases within a patient class, then the aggregate payments to that facility might not be appropriate. Further, the facility might be encouraged to treat only the less costly patients within the patient class causing a potential access problem for the complex cases. Thus, a homogeneous pattern of resource use is a critical characteristic of any patient classification system used in a PPS.

Clinical Meaningfulness

The definition of each patient class should be clinically meaningful. For example, a patient class involving a procedure should, in general, contain only procedures on the same body system, which are of the same degree of extensiveness and which utilize the same method (e.g., surgical, endoscopic, percutaneous, etc.). The underlying assumption in a PPS is that hospitals will respond to the financial incentives in the system and become more efficient. Clinical meaningfulness is critical because in order to respond effectively, hospitals must communicate the incentives to their medical staffs. A clinically meaningful patient classification system will be more readily accepted by providers and will be more useful as a communications and management tool.

Minimal Upcoding and Code Fragmentation

In the patient classification system, there should be minimal opportunities for providers to assign a patient to a higher paying class through upcoding. A patient classification system with many classes that are based on subtle distinctions is susceptible to upcoding. In general, the patient classes should be as broad and inclusive as possible without sacrificing resource homogeneity or clinical meaningfulness. In addition, there should be minimal opportunities for increasing payment by separately reporting the constituent parts of a procedure.

Flexibility

In a visit based payment system, there is a wide array of options in terms of which ancillary services should be included in the visit payment. The extent to which ancillary services are included in the visit payment is a policy decision. The patient classification system must be flexible enough to accommodate a full range of options for incorporating ancillary services into the visit payment. In addition, the patient classification system should be structured to allow changes in technology and practice patterns to be easily incorporated. This system should provide a flexible framework that can adapt to such change without requiring a major restructuring of the classification system.

Because of the fundamental role that the patient classification system plays in a PPS, it is essential that the patient classification system possess substantially

all of the above characteristics. None of the available ambulatory patient classification systems possessed all the characteristics needed in an ambulatory PPS. Existing ambulatory patient classification systems include Ambulatory Visit Groups (AVGs) (Fetter et al., 1984), Products of Ambulatory Care (PAC) (Tenan et al., 1988), Products of Ambulatory Surgery (PAS) (Kelly et al., 1990), Diagnosis Clusters (Schneeweiss et al., 1983) and Ambulatory Surgery Center (ASC) categories (Federal Register, 1991). Significant limitations exist for each of these systems:

- There are a large number of AVGs (i.e., 570) that create opportunities for upcoding. The AVGs also utilized data that are not routinely collected.
- The broad scope of some of the PAS and PAC classes reduced the clinical homogeneity of these classes.
- Diagnosis Clusters do not cover all ambulatory services.
- The ASC categories are not clinically meaningful and do not address medical patients.

None of the existing systems effectively addressed the issue of payment for routine ancillary services. The process of developing the APGs included a review of the approaches used in existing ambulatory patient classification systems. The APGs patient classification system was designed specifically for use as the basis of payment in a visit based ambulatory PPS.

Overview

APGs are designed to explain the amount and type of resources used in an ambulatory visit. Ambulatory resources include pharmaceuticals, supplies, ancillary tests, type of equipment needed, type of room needed, treatment time, etc. Patients in each APG have similar clinical characteristics, resource use, and costs. Similar resource use means that the resources used are relatively constant across all patients within each APG. However, some variation in resource use will remain among the patients in each APG. In other words, the definition of the APG is not so specific that every patient included in the same APG is identical, but rather the level of variation in patient resource use is known and predictable. Thus, although the precise resource use of a particular patient cannot be predicted by knowing the APG of the patient, the average pattern of resource use of a group of patients in an APG can be accurately predicted.

Patients in each APG also have similar clinical characteristics. Similar clinical characteristics mean that the patient characteristics included in the definition of the APG should relate to a common organ system or etiology and that a specific medical specialty should typically provide care to the patients in the APG. In addition, all available patient characteristics that consistently affect resource use should be included in the definition of the APGs. For example, patients with diabetes may or may not have ketoacidosis. Although these patients are the same from organ system, etiology and medical specialist perspectives, the APGs will assign these patients to different patient classes, because the presence of ketoacidosis consistently increases the resource use

of diabetic patients. On the other hand, sets of unrelated surgical procedures should not be used to define an APG because there is no medical rationale to substantiate that resource use would be expected to be similar.

The definition of similar clinical characteristics is, of course, dependent on the goal of the classification system. For APGs, the definition of clinical similarity relates to the medical rationale for differences in resource use. If, on the other hand, the classification goal was related to patient prognosis, then the definition of patient characteristics that were clinically similar might be different. The requirement that APGs be clinically homogeneous caused more patient classes to be formed than is necessary for explaining resource use alone. For example, patients with a dilation and curettage or a simple hemorrhoid procedure are quite similar in terms of most measures of resource use. However, different organ systems and different medical specialties are involved. Thus, the requirement that APGs have similar clinical characteristics precludes the possibility of these types of patients being in the same APG.

APGs were developed to encompass the full range of ambulatory settings including same day surgery units, hospital emergency rooms, and outpatient clinics. APGs, however, do not address phone contacts, home visits, nursing home services or inpatient services. Data from several sources, including hospital outpatient departments and ambulatory surgical centers, were used in developing the APGs. However, better cost data from nonhospital sites are needed in order to determine if there are any problems with applying APGs to nonhospital sites.

Although the anticipated initial application of APGs focuses on Medicare patients, APGs were developed to represent ambulatory patients across the entire patient population. For example, APGs relating to pregnancy were developed even though pregnancy is not often encountered in the Medicare population.

APGs were developed to differentiate facility costs and not professional costs. However, professional costs relate primarily to professional time and, therefore, directly relate to facility time. Professional time can serve as a proxy for the amount of time a patient used the resources of the facility. During the development of APGs, facility costs such as supplies and equipment as well as professional time were taken into consideration.

The data elements used to define APGs were limited to the information routinely collected on the Medicare claim form and consisted of the diagnoses coded in International Classification of Diagnoses 9th Revision Clinical Modifications (ICD-9-CM), procedures coded in Current Procedural Terminology Fourth Edition (CPT-4), age, gender and visit disposition. The patient characteristics used in the definition of the APGs were restricted to those readily available in order to insure that the APGs could be readily implemented (Public Health Service and Health Care Financing Administration, 1980; American Medical Association, 1977).

Selection of the Initial Classification Variable

The first step in developing a patient classification system is to choose the initial classification variable. In the DRGs, the principal diagnosis is used to classify patients into a set of mutually exclusive Major Diagnostic Categories (MDCs). Within each MDC, procedure, age and complication and comorbidities are used to complete the DRG classification system. APGs use procedure instead of diagnosis as the initial classification variable. The decision to do so was based on the following considerations:

- When a significant procedure is performed in an ambulatory setting, it is normally the reason for the visit. The procedure will normally be scheduled in advance and will consume the vast majority of resources associated with the visit.
- With procedure as the initial classification variable, each procedure will be assigned to only one APG. With principal diagnosis as the initial classification variable, the same procedure could be assigned to many different APGs depending on the principal diagnosis. Having each procedure in only one APG also reduces the number of APGs and simplifies the establishment of prospective prices.

Once the decision to use procedure as the initial classification variable was made, it was then necessary to partition all procedures into a set of mutually exclusive and exhaustive procedure groups. The first step in the process was to identify all procedures that could be done only on an inpatient basis. An inpatient procedure was defined as a procedure that requires at least 24 hours of post operative recovery time or monitoring before a patient can be safely discharged. Some procedures, such as craniotomies, are clearly inpatient procedures. However, there are other procedures such as the treatment of an open fracture that are normally done on an inpatient basis but can sometimes be done on an ambulatory basis. Further, patients with the same CPT-4 procedure code can have a great deal of variation in the complexity of the procedure performed. For example, the treatment of an open humeral fracture can vary considerably in complexity.

Only the simplest cases of procedures normally done on an inpatient basis are done on an ambulatory basis. Thus, an open humeral fracture treated on an ambulatory basis will have minimal bone displacement and tissue damage. Such procedures are included in the APG procedure classification. When grouping procedures together to form homogeneous subclasses, it is important to recognize the variations of severity within a CPT-4 code and that only the simplest cases of complex procedures are treated in an ambulatory setting.

The procedures which could be performed on an ambulatory basis were then assigned to one of the following two classes:

Significant Procedure

This is a procedure that is normally scheduled, constitutes the reason for the visit and dominates the time and resources expended during the visit. (e.g., the excision of a skin lesion). Significant procedures range in scope

from debridement of nails to pacemaker replacements as well as significant tests, such as a stress test.

Ancillary Services

The term ancillary services is used to refer to both ancillary tests and ancillary procedures. An ancillary test is one that is ordered by the primary physician to assist in patient diagnosis or treatment. Radiology, laboratory and pathology constitute ancillary tests. An ancillary procedure is a procedure that increases but does not dominate the time and resources expended during a visit, Examples of ancillary procedures are immunizations, or the insertion of an intrauterine device (IUD).

Only patients with a significant procedure were assigned to significant procedure APGs. All medical services provided to the patient were assumed to be an integral part of the procedure. Patients who received medical treatment but who had no significant procedures performed were assigned to Medical APGs. Examples of medical treatments which do not involve a significant procedure include treatment for poisoning, neonatal care, and well care.

Figure 1 illustrates the APG partition based on services rendered or procedures performed. Patients who undergo a significant procedure are assigned to a significant procedure APG. For example, a patient who had a simple skin excision performed to remove a skin lesion would be placed in a significant procedure APG based on the CPT-4 code which describes the precise procedure. Patients receiving medical treatment which does not involve a significant procedure, were assigned to medical APGs. A patient who visited a physician to have a skin lesion evaluated and had no significant procedures performed would be assigned to a medical APG based on the ICD-9-CM diagnosis code. A patient who neither received medical treatment nor underwent a significant procedure, but had an ancillary service performed would be assigned to only an ancillary service APG.

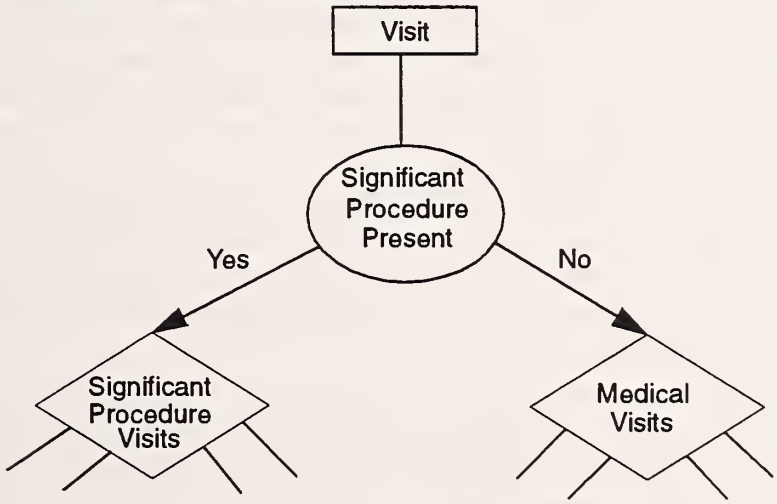

Figure 1 Initial APG Partition Based on the Presence of a Significant Procedure

Development of Significant Procedure Classes

Significant ambulatory procedures are subdivided into groups of CPT-4 codes based on the body system associated with the procedure:

- Skin, Subcutaneous Tissue and Muscle
- Breast
- Bone, Joint and Tendon
- Respiratory, Mouth, Nose and Throat
- Cardiovascular
- Hematology, Lymphatic and Endocrine
- Digestive
- Urinary
- Male Reproductive
- Female Reproductive
- Nervous
- Eye
- Ear

Body systems were formed as the first step toward ensuring that the procedures in each APG were clinically similar. The significant procedures in each body system generally correspond to a single organ system and are associated with a particular medical specialty. The body systems used in the procedure APGs are similar to the (MDCs) for the DRGs. However, there are some significant differences. For example, the body system for skin and subcutaneous tissue includes muscle, whereas muscle is in the musculoskeletal MDC. Muscle was included in the skin and subcutaneous tissue body system because most procedures involving the fascia (connective tissue) are clinically similar to dermal procedures and have similar patterns of resource use. If fascia or muscle procedures were included within the bone and joint body system then it would have been necessary to form separate APGs for muscle procedures. Thus, the inclusion of muscle in the skin and subcutaneous tissue body system reduced the overall number of APGs. Further, there are MDCs for etiologies such as infectious diseases, mental illness and drug abuse for which there are no corresponding body system in the significant procedure APGs.

Some body systems had few procedures performed on an ambulatory basis. For example, except for biopsies or excisions of the thyroid, there are no endocrine procedures performed on an ambulatory basis. Thyroid procedures were included with lymph node biopsies and excisions because they are clinically quite similar.

Once each significant procedure was assigned to a body system, the procedures in each body system were subdivided into clinically similar classes. The classification variables considered in the formation of the procedure classes are shown in Table 1. In general, method was used as the primary classification variable. Different methods such as surgery, endoscopy, manipulation, dilation, catheterization, laser and needle often require different types of rooms, equipment and supplies as well as different amounts of time.

For example, procedures in the respiratory body system were initially divided by method into surgical, endoscopic, needle or catheter and noninvasive test subgroups. On the other hand, most male reproductive procedures are surgical; therefore, the male reproductive body system was initially subdivided on site and not method. Surgical procedures were usually subdivided based on type (i.e., incision, excision, or repair). The time required to perform a procedure depends on the type of procedure, with repairs generally taking the most time. Thus, surgical skin procedures were divided into separate incision, excision and repair groups. Endoscopic procedures were often divided into separate classes depending on purpose (i.e., diagnostic or therapeutic). Therapeutic endoscopic procedures generally require more time. The extent of a procedure was often taken into consideration. Thus, skin excisions of 2 cm and 20 cm are assigned to different APGs

Variable	Example
Site	Face, Hand, etc.
Extent	Excision Size: 2 cm Versus 20 cm
Purpose	Diagnostic or Therapeutic
Type	Incision, Excision or Repair
Method	Surgical, Endoscopic, etc.
Device	Insertion or Removal
Medical Specialty	Urology, Gynecology, etc.
Complexity	Time Needed to Perform Procedure

Table 1 Classification Variables Considered in the Development of the Significant Procedure APGs

Another aspect of extent is the complexity of the procedure. Complexity basically refers to the amount of time normally required to perform a procedure. For example, the excision of a pressure ulcer will generally require more time than the excision of a skin lesion. Thus, the excision of the pressure ulcer was viewed as more complex, and therefore, assigned to a different APG. Anatomical site (e.g., face, hand, etc.) within a body system was used in order to ensure clinical similarity (e.g., procedures of the external ear versus the internal ear), and was also used to implicitly reflect complexity (e.g., treatment of a closed fracture of a finger is usually less complex than treatment of a closed fracture of other sites).

If a procedure involved the insertion of a device (e.g., neurostimulator), then a separate APG was formed in order to recognize the cost of the device. Medical specialty was never explicitly used in the significant procedure APG formation, but procedures normally done by different medical specialties were usually put in different APGs.

The process resulted in the formation of 145 significant procedure APGs.

Development of Medical Classes

Medical APGs describe patients who receive medical treatment but do not have a significant procedure performed during the visit. The fact that a patient had a specific significant procedure performed provides a great deal of precise information regarding the amount and type of resources typically used during the visit. Patients without a significant procedure (i.e., medical patients) can use a wide range of resources depending on the condition of the patient at the time of the visit. Medical patients can be described using the diagnoses of the patient coded in ICD-9-CM which allows both specific diseases (e.g., pneumonia) as well as signs, symptoms and findings (SSFs) (e.g., chest pain, melena, elevated sedimentation rate, etc.) to be coded. The term "diagnosis" will be used to refer generically to SSFs and diseases. The standard Medicare claims form and the ICD-9-CM ambulatory coding guidelines require that the diagnosis that was the primary reason for the visit be indicated. Further, any additional diagnoses that are present may be listed on the claim as secondary diagnoses. The primary variable used to form the medical APGs is the diagnosis coded as the reason for the visit. The reason for the visit is the primary determinant of the resources used (e.g., time, tests ordered, etc.) during the visit. Thus, the medical APGs are based on the type of patient being treated.

The treatment of a medical patient is often highly influenced by the SSFs present at the time of the visit. In general, the coding of a disease simply indicates that the disease was present but gives no indication of how extensive or severe the disease was at the time of the visit. The coding of SSFs in addition to the underlying disease provides some indication of the extensiveness of the disease. The use of SSFs in the definition of the medical APGs was difficult because of the following limitations in the ICD-9-CM codes for SSFs:

- Many of the ICD-9-CM codes for SSFs are not precise. For example, abdominal rigidity (code 7894) has no precise clinical definition.
- There are a large number of SSF codes that refer to abnormal laboratory results that are imprecise. For example, a diagnosis of hypokalemia does not convey useful information because the range of potassium levels associated with hypokalemia can vary significantly in terms of clinical significance.

In addition to the imprecision of many of the SSF codes, the use of SSFs as a primary variable in the medical APGs could create opportunities for upcoding. If the APGs for SSFs had a high payment weight then there would be a financial motivation to code the SSFs instead of the underlying disease. The fact that the ICD-9-CM coding rules allow only nonroutine SSFs to be coded also limited the applicability of SSFs in the definition of the medical APGs. As a result of the problems associated with SSFs, the SSFs used in the definition of the medical APGs were restricted to SSFs with the following characteristics:

- SSFs with a relatively precise clinical meaning
- SSFs that were significant enough not to be a routine part of most diseases
- SSFs that were significant enough to tend to dominate the resources used during the visit. Thus, upcoding is not an issue because assignment to the SSF APG is appropriate irrespective of the underlying disease.

A single major SSF APG for medical patients was formed. Examples of SSFs included in the major SSF APG are meningismus and gangrene. In addition to the SSF codes, there were also ICD-9-CM codes included in the major SSF APG that specify both the underlying disease and the SSF (e.g., diabetic ketoacidosis). A patient is assigned to the major SSF APG whether the major SSF is coded as the reason for the visit or as a secondary diagnosis. The major SSF APG identifies the medical patients with extensive diseases who are usually treated in emergency rooms and who require significant amounts of resources. Patients who have non-major SSFs coded as the reason for the visit, are assigned to the medical APG that is usually associated with the SSF (e.g., cough is assigned to the upper respiratory infection APG).

In addition to the presence of a major SSF, there are also two other indicators that can be used to identify patients with extensive diseases. Patients who die (e.g., trauma or acute myocardial infarction patients) during an ambulatory visit or who are admitted to the hospital following an ambulatory visit often use large amounts of resources. Deaths and hospital admissions are particularly relevant for patients treated in the emergency room. Patients who are admitted through the emergency room have the emergency room charges included in the inpatient bill. However, patients seen in one hospital's emergency room but admitted to another hospital will have an outpatient claim for the emergency room visit. Patients who die or are admitted are atypical and were assigned to a separate APG. The process of forming the medical APGs began with the identification of patients who died or were admitted followed by the identification of patients who had a major SSF.

After patients who died, who were admitted, or who had a major SSF were assigned to separate APGs, the medical APGs were formed primarily on the basis of the ICD-9-CM diagnosis code that was the reason for the visit. Thus, all possible ICD-9-CM diagnoses were divided into a set of mutually exclusive and clinically similar classes. The classification variables considered in the formation of the medical classes are shown in Table 2.

The initial variable used to form the medical APGs was the etiology of the diagnosis that was the reason for the visit:

- Well Care and Administrative
- Trauma
- Mental Diseases
- Pregnancy
- Malignancy
- Poisoning
- Alcohol and Drug Abuse
- Neonate
- Body System

Variable	Example
Etiology	Trauma, Malignancy, etc.
Body System	Respiratory, Digestive, etc.
Type of Disease	Acute or Chronic
Medical Specialty	Ophthalmology, Gynecology, etc.
Patient Age	Pediatric, Adult, etc.
Patient Type	New or Old
Complexity	Time Needed to Treat the Patient

Table 2 Classification Variables Considered in the Development of the Medical APGs

As a first step in the formulation of the medical APGs each ICD-9-CM diagnosis code was assigned to one of the etiology subgroups. Malignancies and trauma were assigned to separate subgroups because they had unique resources associated with the care provided (e.g., frequent radiology and laboratory services). The body system group encompasses a broad spectrum of diseases from acute infectious diseases to chronic diseases such as hypertension. The body system group was then divided into subgroups based on the specific body system of the diagnosis that was the reason for the visit:

- Nervous diseases
- Eye diseases
- Ear, nose, throat and mouth diseases
- Respiratory diseases
- Cardiovascular diseases
- Digestive diseases
- Musculoskeletal diseases
- Skin and Breast diseases
- Endocrine, nutritional and metabolic diseases
- Kidney and urinary tract diseases
- Male reproductive diseases
- Female reproductive diseases
- Immunologic and hematologic diseases
- Infectious diseases

The initial subdivision of the medical APGs is shown in Figure 2. Once all the subclasses based on the etiology and the body system were formed, then the other classification variables in Table 2 were used to further subdivide each etiology and body system.

Whether a diagnosis was acute or chronic was not explicitly used in the formation of the medical APGs. There are medical APGs that contain only diagnoses that are acute or chronic, but a medical APG was never formed for the explicit purpose of identifying acute or chronic diseases. Medical

specialty was never explicitly used in the medical APG formation, but diseases normally treated by different medical specialties were usually put in different APGs. If, for certain diseases, pediatric patients are usually treated differently (e.g., asthma), then patient age was used to form pediatric APGs.

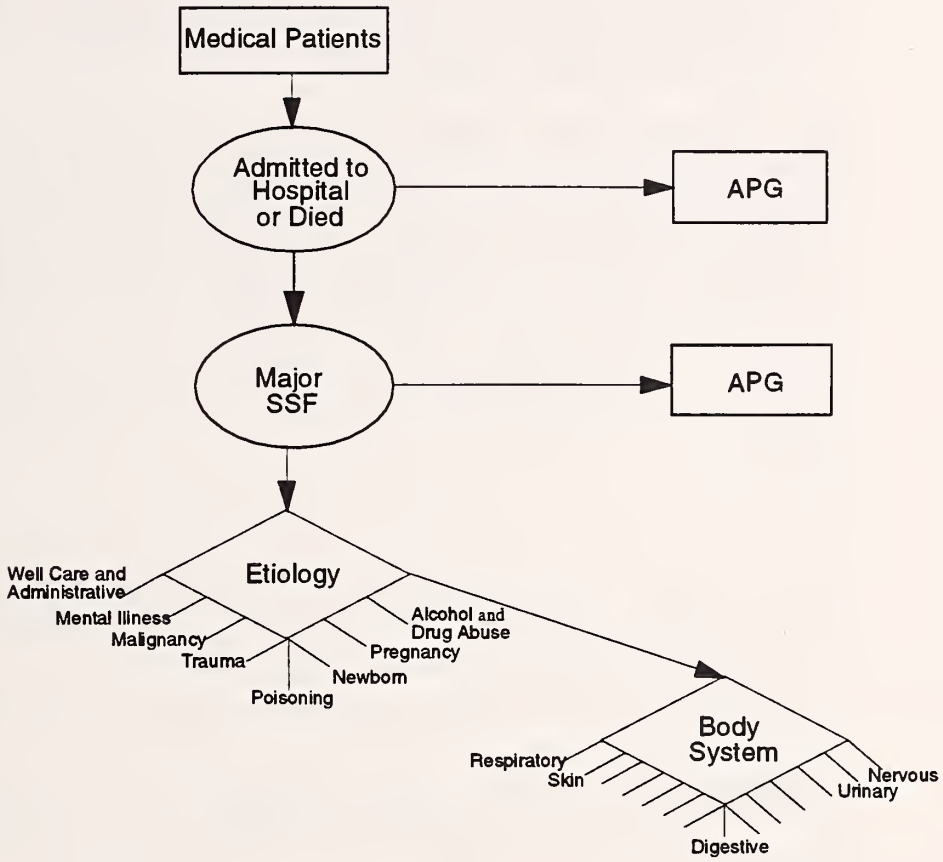

Figure 2 Initial Medical APG Logic

Whether a patient was a new patient or an old patient was considered as a possible variable in the formation of the medical APGs. However, the new patient old patient distinction was not used for the following reasons:

- There is difficulty in establishing a precise definition of a new patient. New can refer to either the physician or the facility. Thus, a patient may be considered new only the first time the patient is treated as an outpatient at the hospital. Alternatively, the patient may be considered new for each visit in which the patient is treated by a different physician. From a resource use perspective, the presence of new diagnoses or problems is often just as important as whether the patient is new to the facility or physician. The only definition of new that is not prone to upcoding is new to the facility.
- The impact on resources of whether a patient is a new patient varies by setting. For emergency room and same-day surgery units, the fact that the

patient is new has little impact on resource use. For an outpatient clinic a new patient often utilizes more resources.

- To the extent that there are follow-up visits for a patient, they typically occur at the same facility as the initial visit. These lower cost visits balance out the often more costly initial visit.
- The designation of whether a patient is a new or old patient is not present on the Medicare UB-92 claim form. Thus, a change in reporting requirements would have been necessary.

Patient complexity basically refers to the amount of time and tests normally required to treat a patient. In a visit based payment system, visit time is an important determinant of facility fixed cost because it directly affects both the number of visits that can be provided and the amount of overhead costs that are allocated to each visit. In forming the medical APGs, visit time was considered an important factor in the determination of resource use and the associated facility cost. Thus, separate medical APGs were formed to recognize differences in visit time. For example, a visit for a skin malignancy normally takes considerably less time than a visit for a hematological malignancy.

The final issue that was considered in the formation of the medical APGs was the amount and type of ancillary services that are typically provided to a patient. Because the cost of some ancillary services would be included in the base visit payment, patients with different profiles of ancillary service use needed to be in different APGs.

The process resulted in the formation of 80 medical APGs.

Development of Ancillary Service Classes

Ancillary services refer to ancillary tests (i.e., laboratory, radiology and pathology) and ancillary procedures (e.g., immunization, anesthesia, insertion of an IUD, etc.). Ancillary APGs were formed for each type of ancillary service.

Laboratory

The laboratory department in which the laboratory test is typically performed was used as the primary variable in the formation of the laboratory APGs. Thus, tests performed by the different laboratory departments (e.g., hematology, microbiology, toxicology, etc.) were assigned to different APGs. The testing method (e.g., radioimmunoassay) was used to a limited extent when the method represented a substantially different type of test with relatively clear indication for usage. However, in general, different methods of performing the same test were placed in the same APG. A laboratory technician will typically employ different methods depending on the precision of result that is needed. However, different methods are also employed depending on the training of the laboratory professional. For example, although there is a clear difference

between a fluorimetric versus chromatographic method in the determination of the calcium level, there frequently are not precise indications on when to do one versus the other. As a consequence, the different methods for performing the same test were usually assigned to the same APG. The same type of laboratory test (e.g., chemistry) was sometimes differentiated by the source of specimen (e.g., blood versus urine) in order to account for the labor cost of collecting and transporting the specimen. Finally, the same type of laboratory test was usually differentiated based on the complexity of the test. Tests that required more time, technicians with greater skill levels or expensive equipment were assigned to different APGs. For example, multichannel chemistry tests were assigned to a separate APG from other chemistry tests because of the cost of the equipment used to perform a multichannel chemistry test. Laboratory tests that required no equipment and are typically performed during a visit (e.g., blood or urine dipstick tests) were assigned to a single APG as a result of their very low level of complexity. During the development of the laboratory APGs, physicians who either headed or worked in hospital laboratory departments and technicians who perform the test were consulted. In addition, the laboratory relative value units (RVUs) developed by the College of American Pathologists were utilized. There are a total of 23 laboratory APGs.

Radiology

The type of equipment (magnetic resonance imaging [MRI], computerized assisted tomagraphy [CAT], plain film, etc.) was the primary classification variable for the radiology APGs because the cost of the radiology equipment varies considerably across the different types of radiological procedures. Diagnostic x-rays were distinguished based on whether a radio-opaque contrast media was used because there are additional costs associated with the supply cost of the contrast media and the injection of the contrast media. Diagnostic x-rays requiring a radio-opaque contrast media were divided based on the anatomic site studied because the anatomic site, in general, reflected the complexity of the procedure. Nuclear medicine was separated into diagnostic and therapeutic groups. There are a total of 20 radiology APGs.

Pathology

Pathology was divided into two APGs based on the complexity of the pathology test. Pathology tests requiring more time or greater skill levels were assigned to the complex pathology APG.

Anesthesia APG

All of anesthesiology was assigned to a single APG. The APG payment system includes the cost of anesthesia in the payment for a significant procedure. The CPT-4 codes do not differentiate between general and local anesthesia and it was therefore not possible to create separate general and local anesthesia APGs. However, the procedures in each significant procedure APG typically have the same type of anesthesia

administered. Thus, the absence of a differentiation on the type of anesthesia did not present a problem.

Ancillary Tests and Procedures

Other ancillary tests include electrocardiograms, other electrocardiographic tests and vestibular function tests. Ancillary procedures are procedures that do not dominate the time and resources expended during a visit, but do increase the time and resources expended during a visit. Thus, ancillary procedures can be performed as part of a medical visit and do increase the cost of the medical visit. Ancillary procedures include immunizations, introduction of needles and catheters, simple anoscopy, biofeedback and hypnotherapy, infusion therapy, minor urinary tube changes, minor gynecological procedures and minor ophthalmological procedures. Immunizations were divided into three APGs based primarily on the cost of the vaccine (e.g., rabies vaccination is considered a complex immunization). There are a total of 15 ancillary test and procedure APGs.

Chemotherapy

There are two significant procedure APGs for chemotherapy that are based on the route of administration of the chemotherapy (i.e., intravenous push versus continuous infusion). These two significant procedure APGs reflect the difference in supplies and the labor cost of monitoring the administration of the chemotherapy drug. There is a second major cost component associated with chemotherapy and that is the cost of the chemotherapy drug. Chemotherapy drug costs can vary considerably and, therefore, three additional chemotherapy APGs were formed to reflect the costs of chemotherapy drugs. Thus, the payment for a chemotherapy visit is composed of two APGs, one for the route of administration and one for the chemotherapy drug.

Summary of Development

The process of formulating the APGs was highly iterative, involving statistical results from historical data combined with clinical judgment. A preliminary classification was developed based solely on clinical judgment. The preliminary classification was then evaluated using several databases including both Medicare and non-Medicare patients and contact time between provider and patient as well as charge data. The data bases used in the evaluation were as follows:

- 1987 Part B Medicare annual data consisting of summary charge data by CPT-4 code.
- 1987 Medicare outpatient sample consisting of a 5 percent outpatient sample containing 232,827 procedure claims.
- 1988 Medicare outpatient data containing all Medicare hospital outpatients with a date of service from the last two weeks of October 1988 totalling 1.6 million outpatient claims.

- 1988 New York State data containing approximately 400,000 claims from New York hospitals and community health centers including contact time between provider and patient.
- 1985 National Ambulatory Care Survey Data consisting of 72,000 visits drawn from 2,789 office-based physicians that included contact time between provider and patient.
- U.S. Army Ambulatory Care data base consisting of 516,006 visits to army hospitals and clinics that included contact time between provider and patient.
- Relative Value Scales including Relative Values for Physicians (Relative Value Studies, Inc., 1984) and the Resource Based Relative Value Scale (RBRVS) (Hsaio et al, 1988).

The preliminary patient classes formed, based on clinical judgement, were evaluated using reports that displayed aggregate frequency and charge statistics as well as available RVU scales. The report for significant procedure and ancillary service APGs displayed for each CPT-4 code within an APG the count, mean charge and standard error of charges from each data base as well as the available RVU scales. Using this report, the CPT-4 codes that comprise each APG were evaluated across all data bases and RVU scales simultaneously. The evaluation looked for consistency of average charges across the CPT-4 codes within an APG across all the data bases as well as for consistency across the available RVU scales. The report for the medical APGs displayed for each ICD-9-CM diagnosis code the summary statistics for charges and visit time. The evaluation of the medical APGs looked for consistency of average charges and visit time across the ICD-9-CM codes within an APG across all the data bases. As the APGs were being formed, the definitions were circulated to clinical consultants for comments on clinical appropriateness. Nearly 100 professionals throughout the country commented and consulted on the construction of the APGs. This process of defining APGs and reviewing them both clinically and with the data was repeated numerous times. The overall objective of the process was to have clinically similar groups of patients with similar resource use but to achieve these objectives with as few APGs as possible.

During the formation of DRGs, charge data was, in general, found to reflect the relative needs of patients. The number of bed-days and ancillary services consumed by inpatients depended on their needs. However, hospital ambulatory charges are also highly influenced by physician charges. A great deal of effort has been expended in the development of RVUs, such as the RBRVS developed for physician payment (Hsaio et al., 1988). RVU systems have been widely used for many years (Relative Value Studies, Inc., 1984). Ambulatory charges for a procedure do not necessarily reflect the actual needs or complexity of an individual patient but are often based on the established RVU for the procedure. As a consequence, statistical results from charge data often simply reflect the established RVU scales. Although charge data were used extensively in the APG development, it was necessary for the clinical team to make judgments on whether observed hospital charge differences

across different procedures reflect real differences in the resources required to perform the procedure or any bias in the established RVU scales.

For example, there are different CPT-4 codes for excisions of benign and malignant skin lesions. RVU and charge data implied that excisions of malignant skin lesions of the same site and size used significantly more resources than benign skin lesions. However, the histology of the lesion is usually not known at the time of the procedure, but is established when a pathology report is returned. Further, the excision of a malignant and benign skin lesion of the same site and size is fundamentally the same procedure except that a wider margin is excised for lesions that are suspected to be malignant. Thus, the significant procedure APGs do not differentiate between malignant and benign skin excisions. In addition, procedure APGs avoid assigning procedures to different APGs based on subtle or easily gameable distinctions in the CPT-4 codes. For example, deep and superficial muscle biopsies are in the same APG because the distinction between deep and superficial lacks a precise definition in the CPT-4 coding system.

The development of the APGs required a balance between the number of APGs, clinical consistency and homogeneity in charges and visit time. Clinical consistency was required in order for any procedures or diagnoses to be grouped into an APG. However, in general, APGs were not formed solely on clinical grounds. Verification of consistent differences in charges or visit time was required in order to form an APG. In general, infrequent APGs were not formed unless there was strong clinical justification and a large charge difference. For example, pacemaker replacements are infrequent on an outpatient basis, but pacemaker replacements do represent a clinically distinct group of patients with a very high cost. Thus, a pacemaker replacement APG was formed. The end result of the process of forming the APGs is a clinically consistent group of patient classes that are homogeneous in terms of resource use. The process of forming the APGs resulted in a total of 299 APGs as shown in Table 3. The APGs describe the complete range of services provided in the outpatient setting. The APGs can form the basic building blocks for the development of a visit-based outpatient prospective system and can provide a flexible structure for configuring a payment system to meet specific policy objectives.

The APG Payment System

In the APG payment system a patient is described by a list of APGs that correspond to each service provided to the patient. The assignment of multiple APGs to a patient is in contrast with the DRG system that always assigns an inpatient to a single DRG. If a patient has multiple procedures then the DRGs use a procedure hierarchy to select the most appropriate DRG. The DRG payment includes the cost of all ancillary services provided to the patient. In the outpatient setting, the diversity of sites of service (i.e., same day surgery units, emergency rooms and outpatient clinics), the wide variation in the reasons patients require outpatient care (e.g., well care to critical trauma care) and the high percentage of cost associated with ancillary services (i.e., the cost of ancillary services can often exceed the cost of the base visit)

necessitates a patient classification scheme that can closely reflect the services rendered to the patient. The APGs address the diversity within the outpatient setting by assigning patients to multiple APGs when needed. For

Type of APG	Count
Significant Procedure	145
Medical	80
Laboratory	23
Radiology	20
Pathology	2
Anesthesia	1
Ancillary Tests and Procedures	15
Chemotherapy Drugs	3
Incidental	8
Admitted or Died	1
Error	1
Total	**299**

Table 3 Types of APGs

example, if a patient had two procedures performed plus a chest x-ray and a blood test, then there would be four APGs assigned to the patient (i.e., one APG for each procedure plus the APGs for the chest x-ray and the blood test). In a PPS, each APG would have a standard payment rate, and the payment for a patient could be computed by summing the payment rates across all the APGs assigned to the patient. However, in order to provide incentives for efficiency and to minimize opportunities for upcoding of APGs, not all the APGs assigned to a patient are used in the computation of the payment. The APG system uses three techniques for grouping different services provided into a single payment unit: Significant Procedure Consolidation, Ancillary Packaging, and Multiple Significant Procedure and Ancillary Discounting.

Significant Procedure Consolidation

When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources. Significant procedure consolidation refers to the collapsing of multiple related significant procedure APGs into a single APG for the purpose of the determination of payment. A significant procedure consolidation list was developed based on clinical judgement. The significant procedure consolidation list identifies, for each significant procedure APG, the other significant procedure APGs that are an integral part of the procedure and can be performed with relatively little additional effort and are therefore, consolidated. For example, the diagnostic lower gastrointestinal (GI) endoscopy, the proctosigmoidoscopy and the

anoscopy APGs are consolidated into the therapeutic lower GI endoscopy APG. Conversely, unrelated significant procedures are not consolidated by the significant procedure list. For example, the treatment of a closed fracture and the suturing of a skin laceration result in two significant procedure APGs being used in the computation of the payment. Multiple unrelated significant procedures performed during the same visits are not consolidated in order to provide a fair level of payment and to avoid creating the incentives to have separate visits for each procedure.

Significant procedure consolidation also greatly reduces the opportunities for the fragmentation of procedures for the purpose of increasing payment. For example, all minor skin procedures are consolidated into the significant procedure APGs that involve penetration of the skin (e.g., hernia repair). Because all procedures in the same APG and all significant procedures that can be performed as part of another significant procedure are consolidated into a single APG for payment purposes, fragmentation opportunities are minimized.

Ancillary Packaging

A patient with a significant procedure or a medical visit may have ancillary services performed as part of the visit. Ancillary packaging refers to the inclusion of certain ancillary services into the APG payment rate for a significant procedure or medical visit. For example, a chest x-ray is packaged into the payment for a pneumonia visit. The packaging of ancillaries does not imply that there would be no payment associated with the packaged ancillary. The cost of the packaged ancillaries would be included in the payment amount for the significant procedure or medical APG. For example, if a packaged ancillary cost $20 and is performed for 50 percent of the patients in a medical APG, then $10 (i.e., 50 percent of $20) would be included in the payment rate for the medical APG.

Under Medicare's DRG-based PPS for hospital inpatient care, all ancillary services provided to a patient are packaged into the payment for the DRG to which the patient is assigned. Because of the nature of outpatient care, it is not clear that all services provided or ordered during a visit can be packaged into one payment rate. Medicare's current payment system for ambulatory care involves separate payments for ancillary services provided in conjunction with a visit. Ancillary packaging will allow the Medicare program to make a single payment for a well defined package of ambulatory services, thereby creating a consistent definition of services across providers. Packaging will give providers the incentive to improve their efficiency by avoiding unnecessary ancillaries and by substituting less expensive but equally effective ancillary services for more costly options.

There are also some potential problems in the packaging of ancillaries. Packaging places providers at financial risk. If expensive ancillaries that are not usually performed for a particular type of visit are included in the packaged payment then the financial risk may be excessive. For example, if a $500 test that occurs on average only once per hundred visits was packaged, then the packaged payment for each visit would include only $5 for this test.

Therefore, only relatively inexpensive, frequently performed ancillaries are packaged. The 1988 Medicare data was used to evaluate ancillary charges and frequency. For example, a laboratory test was considered inexpensive if its average charge in the database was less than $40.

There are basically two alternative approaches to packaging: partial packaging or all inclusive packaging. Under partial packaging, ancillary services that are inexpensive or frequently provided, are packaged into the payment for the significant procedure or medical visit. However, other ancillary services, particularly those that are expensive or infrequently performed (such as MRIs), are paid as separate ancillary APGs. Partial packaging limits the providers' risk. Under an all inclusive packaging, all services (including expensive ancillaries) that are provided during a visit are packaged into the visit payment. The partial packaging option is the most appropriate option because it does not impose a high level of risk for providers.

Because partial packaging was utilized in the APG payment system, the subset of ancillary services that would be packaged into a procedure or medical visit needed to be determined. There are two approaches to selecting the ancillaries to be packaged: clinical or uniform.

A clinical packaging approach selects the ancillaries to be packaged on an APG specific basis. The ancillaries to be packaged are selected primarily on clinical grounds. Thus, only ancillaries that are clinically expected to be a routine part of the specific procedure or medical visit are packaged. The clinical approach has the benefit that the resulting package for a visit is clinically meaningful.

The alternative to clinical packaging is to develop a uniform list of ancillaries that are always packaged into every significant procedure or medical visit. There are several advantages associated with a uniform packaging of ancillaries. A uniform packaging is administratively simple. Once the uniform list of ancillaries is developed, both the Medicare fiscal intermediaries and providers will know that every ancillary on the list is always packaged. Thus, the tracking of the ancillaries that are packaged is straightforward. Further, a uniform list of packaged ancillaries is simple for hospitals to explain to their medical staff and thus, the incentive to efficiently utilize the packaged ancillaries can be effectively communicated. A uniform list of ancillaries is less prone to manipulation by providers. With a clinical packaging of ancillaries, procedure or medical visits have different levels of ancillaries packaged across the different APGs. Thus, there is an incentive to code the patient into the significant procedure or medical APG with the fewest packaged ancillaries. This presents a particular problem for medical visits in which multiple diagnoses are present. For medical visits with multiple diagnoses, the ancillary tests may be performed for the secondary diagnoses. Under a clinical packaging, low cost nonroutine tests are not packaged into the visit payment. This provides a financial incentive for providers to perform such nonroutine tests. A uniform packaging includes a wider array of

ancillaries in the packaging for each APG and thus, there is less opportunity for additional payments from nonroutine ancillaries.

A uniform packaging of ancillaries was selected for use in the APG payment model. An attempt to develop a clinical packaging of ancillaries proved difficult. The administrative simplicity, the relative freedom from manipulation and the wider scope of uniform packaging of ancillaries led to its adoption.

The ancillary APGs included in the uniform packaging are contained in Table 4. The APGs included in the uniform packaging were primarily simple laboratory tests (e.g., basic chemistry), simple pathology, anesthesia, simple radiology (e.g., plain films), other minor tests (e.g., electrocardiograms) and minor procedures and therapies (e.g., spirometry). In general, the ancillaries in the uniform packaging included ancillaries that are performed for a wide range of different types of visits and were relatively low cost compared with average cost of the procedure and medical APGs. Only relatively low cost ancillaries were included in the uniform packaging because if high cost ancillaries were packaged into the visit payment, the patients who required such ancillaries would cause a substantial financial loss for the hospital. The list of ancillaries included in the uniform packaging is a policy decision. The cost of medical surgical supplies, drugs and all other facility related costs are included in the payment for a significant procedure or medical visit. The only exception is the cost of chemotherapy medication because it is frequently very costly.

Discounting

When multiple unrelated significant procedures are performed or when the same ancillary service is performed multiple times, a discounting of the APG payment rates can be applied. Discounting refers to a reduction in the standard payment rate for an APG. Discounting recognizes that the marginal cost of providing a second procedure to a patient during a single visit is less than the cost of providing the procedure by itself. For example, discounting could compensate for the reduced cost per procedure of doing multiple significant procedures at the same time. When multiple significant procedures are performed, in general, the patient preparation, use of the operating room and recovery time is shared between the two procedures. Thus, the cost of doing two procedures at the same time is less than the cost of doing the two procedures at two different times. Discounting can also be used to provide a financial incentive not to repeat the same ancillary service multiple times. Because the performance of multiple ancillaries in the same APG may be clinically necessary and appropriate, there is no consolidation of ancillaries within the same APG. Thus, each nonpackaged ancillary in the same APG will result in an additional payment. However, in order to provide some financial incentive not to repeat ancillary tests, multiple ancillaries in the same APG could be discounted. The level of any discounting is a policy decision and would be determined during system implementation.

APG	APG Description
345	Obstetrical Ultrasound
351	Plain Film
365	Anesthesia
391	Simple Pathology
419	Simple Immunology Tests
421	Simple Microbiology Tests
423	Simple Endocrinology Tests
425	Basic Chemistry Tests
426	Simple Chemistry Tests
428	Multichannel Chemistry Tests
429	Simple Toxicology Tests
431	Urinalysis
434	Simple Clotting Tests
436	Simple Hematology Tests
439	Lithium Level Monitoring
440	Blood and Urine Dipstick Tests
443	Spirometry and Respiratory Therapy
447	Cardiogram
449	Simple Immunization
450	Moderate Immunization
452	Minor Gynecological Procedures
454	Minor Doppler, and ECG Monitoring
455	Minor Opthalmological Injections, Scrapings and Tests
456	Vestibular Function Tests
457	Minor Urinary Tube Change
458	Simple Anoscopy
459	Biofeedback and Hypnotherapy
460	Provision of Vision Aids
461	Introduction of Needles and Catheter

Table 4 Ancillary APGs Included in Uniform Packaging

The three components of an APG payment system are shown in Figure 3. In this example, although there are four APGs assigned to the claim, only two of the APGs are used to compute the final payment amount. The diagnostic lower GI endoscopy (APG 164) is consolidated into the therapeutic lower GI endoscopy (APG 165). The simple surgical pathology (APG 391) is packaged, but the CAT scan (APG 349) is not. A visit-based APG PPS with significant procedure consolidation, uniform ancillary packaging and multiple APG discounting would have many advantages over the current outpatient payment method such as the following:

- Many similar units of service are aggregated together, greatly reducing the number of units of service.
- The need to establish separate payment rates for minor differences in the unit of service is eliminated.
- The opportunity for unbundling the units of service is greatly reduced.
- There is a financial incentive to use packaged ancillary services efficiently.
- Multiple procedures during a visit are reasonably compensated, but not excessively rewarded
- Payment of medical visits is based on the type of patient treated and not on the level of effort reported by the physician.

The structure of the APG payment model provides considerable flexibility. By modifying the level of significant procedure consolidation, ancillary packaging and discounting, the incentives in the system can be altered in order to achieve specific policy objectives.

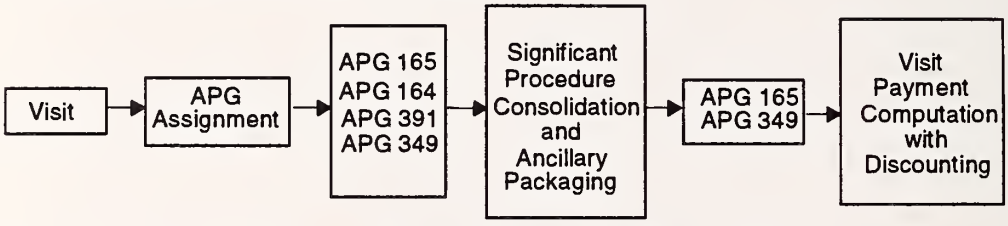

Figure 3 APG Payment System

APG Payment Simulation

In order to evaluate the APG payment model, a payment simulation on historical Medicare data was performed. The objective of the APG payment simulation was to compute charge based weights for each APG and to compare the APG-based payments with historical Medicare charges. Historical charges provide a measure of the relative amount of hospital resources used to treat a patient during an outpatient visit. The Medicare inpatient PPS uses historical charges to compute the relative DRG payment weights. In general, differences in charges reflect differences in the hospital services provided. On a per claim basis, the APG payment simulation compares the total APG payment for a claim with the historical charge for the claim. The expectation is that the total APG payment will reflect the relative

variation in historical charges. During the development of APGs, decisions were made on clinical grounds not to have APGs reflect certain differences in historical charging practices (e.g., differences in historical charges for setting a fracture with and without manipulation are not reflected in the APGs). Thus, there are differences between the APG payments and historical charges that are caused by intentional departures from historical charging practices. In addition, the combined payment effect of the aggregation of individual procedures and diagnoses into APGs, the significant procedure consolidation, the ancillary packaging and the discounting will result in significant differences between the APG payment for an individual patient and the historical charges. The APG payment simulation computed a single set of national APG charge based weights and compared the resulting APG payments with historical charges.

Payment Simulation Data base

The database used to evaluate the initial APG payment model was from the two week Medicare outpatient sample, consisting of all Medicare hospital outpatient claims with a date of service from the last two weeks in October 1988. The 1988 Medicare sample data was divided into two equal size random subsamples. The first subsample was used as one of the databases analyzed during the development of the APG definitions. The second subsample was used in the APG payment simulation and contained 763,934 hospital outpatient claims.

An extensive editing process was developed in order to eliminate claims with errors, inconsistencies, or ambiguities. Examples of such edits were multiple visits on the same claim, invalid CPT-4 codes and inconsistencies in procedures and charges (e.g., anesthesia charges on a claim with no procedures, etc.). The edits were quite stringent and eliminated 28.3 percent of the claims from the analysis (216,529 claims).

Once the data were edited, the next step in the payment simulation was to define trim points in order to eliminate the extreme charge values from the computation of the average APG charge. In the computation of the inpatient DRG payment weights, claims with charges that were more than three standard deviations above the mean of the log of charges were eliminated. The outpatient data also contained claims with very low-charge values (e.g., near zero). Therefore, a data trimming method was selected that trimmed both the extreme low and high values of charge. A non-parametric trimming method using the interquartile range of charges was selected (Andrews et al., 1972). A total of 5.39 percent of the edited claims were trimmed (29,600 claims). After editing and trimming, there were 517,805 claims used in the analysis database.

In order to provide a comparison with the DRGs, a random sample of 1,021,811 Medicare inpatient discharges from 1988 was obtained. Using Version 7.0 of the DRGs, (i.e., the Fiscal Year 1988 version), low and high charge trim points were computed using the same interquartile range

trimming method that was applied to the APGs. A total of 4.42 percent of the claims in the inpatient data were trimmed.

Combinations and Frequency

Table 5 summarizes, for the edited and trimmed database, the number of claims and total charges for the three different types of claims. Although significant procedure claims constitute only 13.95 percent of the claims, they account for 52.73 percent of the charges. Conversely, although ancillary-only claims constitute 54.21 percent of the claims, they account for only 27.47 percent of the charges.

	Number of Claims	Percent of Claims	Charges ($Millions)	Percent of Charges
Significant procedure claims	72,251	13.95	57.24	52.73
Medical claims	164,857	31.84	21.50	19.80
Ancillary APGs	280,697	54.21	29.82	27.47

Table 5 Number of Claims and Total Charge by Type of APG

Using the edited and trimmed data, the coefficient of variation of charges for each APG was computed. Table 6 shows a comparison of the weighted coefficient of variation of charges across the different types of APGs and DRGs. The weighted coefficient of variation is computed by weighting the coefficient of variation of each APG (or DRG) by the percent of claims in that APG (or DRG) and summing across all the APGs (or DRGs). As can be seen from Table 6, the weighted coefficient of variation of charges for the APGs is comparable with the weighted coefficient of variation of charges for the DRGs. The weighted coefficient of variation of charges for trimmed data for procedure claims is 0.56 for both APGs and DRGs. For medical claims, the weighted coefficient of variation is 0.85 for APGs and 0.66 for DRGs. The probable reason for the medical APGs having a higher weighted coefficient of variation compared to the medical DRGs is that the packaged ancillaries constitute a large proportion of the total charge of a medical visit.

Using the edited and trimmed data, the charge based weights for each APG were computed. The charge based weights are expressed in dollars and are a measure of the relative historical charges associated with each APG. Although the charge based weights are expressed in dollars, they do not represent actual payment amounts that would be based on actual costs. Historical outpatient hospital charges are approximately 42 percent higher than historical outpatient hospital cost (Miller and Sulvetta, 1990). Thus, the charge based weights represent relative amounts and are not representative of actual APG payment levels for Medicare. The charge based weights are divided into the direct portion of the APG payment and the portion that results from the ancillary packaging. The direct portion of the APG charge based weight consists of the charge for the procedure or medical visit itself plus the

	Weighted CV				R^2			
	APGs		DRGs		APGs		DRGs	
	Untrim	Trimmed	Untrim	Trimmed	Untrim	Trimmed	Untrim	Trimmed
Procedure claims	0.73	0.56	0.95	0.56	0.52	0.74	0.22	0.46
Medical claims	1.40	0.85	1.07	0.66	0.18	0.38	0.21	0.41
Procedure and medical claims combined	1.23	0.78	1.04	0.63	0.58	0.79	0.27	0.50
Ancillary only claims	1.30	0.54	–	–	0.67	0.81	–	–

Table 6 Weighted Coefficient of Variation and R^2 of Charges for APGs and DRGs

charges for additional items such as pharmacy and medical surgical supplies. The average charge based weight and percent packaged for each APG are summarized in Table 7.

The significant procedure APGs have average charge based weights that are more than six times higher than the average charge based weight for the medical APGs. The medical APGs have a much higher percentage of the APG charge based weight from packaged ancillaries than the significant procedure APGs (i.e., 32.31 percent versus 11.83 percent, respectively). The low percent of the charge based weights associated with the packaged ancillaries indicates a relatively low financial risk to hospitals resulting from the packaging of ancillaries. Across the APGs with at least 100 claims, the APG with the highest percent of the APG charge based weight from packaged ancillaries is the medical APG for pneumonia (APG 783) at 54.51 percent. The high percent of packaged ancillaries associated with pneumonia is the result of the packaging of the chest x-ray and the simple laboratory tests that are usually performed for a pneumonia patient. The top 23 APGs in terms of the percent of the charge based weight from packaged ancillaries are all medical APGs.

	Average Charge Based Weight	Percent Packaged
Significant Procedure Claims	$750.10	11.83
Medical Clams	$117.51	32.31
Significant Procedure and Medical Claims Combined	$305.11	26.24
Ancillary Service APGs	$46.75	0.0

Table 7 Average Charge Based Weight And Percent Packaged

The high percent of the charge based weight from packaged ancillaries for medical patients is primarily the result of the relatively low payment for a medical claim. Across the APGs with at least 100 claims, the APG with the lowest percent of the APG charge based weight from packaged ancillaries is the significant procedure APG for simple laser eye procedures at 0.3 percent. The 17 APGs with the lowest percent of the charge based weight from packaged ancillaries are all significant procedure APGs. The charge based weights are quite consistent with expectations. The APGs with the highest charge based weight are low volume significant procedure APGs involving expensive medical surgical supplies or equipment (e.g., pacemaker replacement). The significant procedure APGs with lowest charge based weights were therapy APGs (e.g., physical therapy). The medical APG for major SSFs had more than double the average charge based weight of the next highest medical APG. For ancillary service APGs, the APGs with the highest charge based weights were the radiological tests using expensive equipment (e.g., MRI). Laboratory tests tended to have relatively low charge based weights (e.g., urinalysis had the lowest charge based weight).

Although, in general, the charge based weights are consistent with clinical expectations, there are several results that were unexpected. For example, the APG for skin and integument grafts had a lower charge based weight than the APG for complex skin repairs. This result was unexpected because the cost of obtaining the grafts is included in the charge based weight for the skin and integument grafts APG. These two APGs are clinically quite distinct and need to be maintained as separate APGs. The consistency of the charge based weights with clinical expectations demonstrates that the procedure and diagnostic coding on ambulatory claims is reasonably reliable.

None of the discrepancies observed was significant enough to cause any reconsiderations of the definition of any of the APGs. As more accurate data are collected and used to compute APG charge based weights, the APGs should conform more closely to clinical expectations. The relatively minor discrepancies are not surprising, because the APG charge based weights represent the first attempt to use historical Medicare procedure, diagnostic, and charge information to compute prospective charge based weights. Indeed, the initial DRG payment rates used in the first two years of PPS contained several discrepancies (Federal Register, 1983). For example, for five pairs of DRGs, patients with a complication or comorbidity had a lower payment weight than patients those without. Once the DRG payment rates were recomputed with more accurate data, all the discrepancies were eliminated. The experience with the DRGs emphasizes the importance of relying on clinical expectations when developing the initial version of a patient classification system.

Payment Simulation Statistical Results

For each claim, a total APG payment was computed. The relationship between the historical charge and the total APG payment was compared using

a least-squares regression (R^2). A least-squares regression measures the ability of the total APG payment amount to predict the historical charge and provides a measure of the amount of variance in charges explained by the APG cost model.

The Medicare inpatient data was used to compute the R^2 for the DRGs. In the payment model used for the DRG analysis, the payment for each patient was computed as the average charge for the DRG to which the patient was assigned. In the computation of the R^2 for both the APGs and DRGs, the payment amount computed for each claim is unadjusted for wage-rate difference or other factors that can effect hospital costs. The resulting R^2 for the APGs and DRGs are shown in Table 6.

The R^2 for DRGs for untrimmed charges is comparable to the results previously reported in the literature. For example, in a Yale University report the R^2 for DRGs for untrimmed charges for Medicare data was reported as 0.28 (Fetter et al., 1989).

The R^2 obtained for trimmed data for procedure and medical claims for the APGs was higher than for the DRGs (0.79 for APGs versus 0.50 for DRGs). For procedure claims. the APGs had a much higher R^2 than the DRGs (0.74 for APGs versus 0.46 for DRGs). For medical claims, the DRGs had a slightly higher R^2 than the APGs (0.38 for APGs versus 0.41 for DRGs). The R^2 for the procedure and medical claims combined is higher than either the procedure or medical claims separately. This is caused by the fact that the charges for procedure claims are much higher than the medical claims. Thus, the medical claims and procedure claims form disjoint sets. When the medical and procedure APGs are pooled together, the linear relationship between payments and charges is strengthened.Thus, based on R2, the APGs have stronger association between payments and historical charges than DRGs. The ancillary only claims have a high R^2 (0.81).

In general, the APGs perform well compared with DRGs. Indeed, for R^2 on trimmed data, which is the most commonly reported statistic, the APGs have an R^2 that is 58 percent higher than the DRGs (0.79 for APGs versus 0.50 for DRGs).

Conclusions

A visit-based APG PPS can provide a useful system for the payment of the facility component of hospital- based outpatient care. The structure of the APG payment model provides considerable flexibility. The level of significant procedure consolidation, ancillary packaging and discounting can be altered in order to change the incentives in the system and achieve specific policy objectives.

The APGs form a manageable, clinically meaningful set of patient classes that relate the attributes of patients to the resource demands and associated costs experienced by a hospital outpatient department. As coding rules change, as more accurate and comprehensive data are collected, or as medical

technology or practice changes, the APG definitions can be modified to reflect these changes. Together the APG patient classification and the APG payment model constitute a flexible framework for establishing an outpatient PPS.

End Notes

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APPENDIX B

APG Collapsing Algorithm

The APG Collapsing Algorithm is applied when there are multiple claims for the same patient on the same day at the same provider and at least one of the claims is a significant procedure or a medical visit. Collapsing means that the separate claims are collapsed into a single visit record.

1. The body system mapping list contained in this Appendix defines a body system (BS) mapping of APGs.
2. For the different claim combinations, the following actions were taken:

Claim Combinations	No Ancillary Only Claims	with Ancillary Only Claims
One significant procedure	—	Collapse
Multiple significant procedures	Collapse if in same BS	Collapse if SPs in same BS
One SP, one medical	Collapse if in same BS	Collapse if SP and meds in same BS
Multiple SP, one medical	Collapse if all in same BS	Collapse if all SPs and meds in same BS
One medical	—	Collapse
Multiple medical	Collapse if similar diagnoses	Collapse if similar diagnoses
Multiple SP, multiple medical	Collapse if all SP and meds in same BS and meds have similar diagnoses	Collapse if all SP and meds in same BS and meds have SD
One sp, multiple medical	Collapse if SP and meds in same BS and meds have similar diagnoses	Collapse if SP and meds in same BS and meds have SD

Similar diagnoses are defined as having the same medical APG for the first listed diagnosis and (if present) identical secondary diagnoses. Claims that are not collapsed are treated as separate visits if there are no ancillary only claims present. Otherwise, if ancillary only claims are present, these claims are considered ambiguous and are edited from the analysis database. The body system mapping is in terms of Version 1.0 APGs. The collapsing algorithm was not rerun after the Version 2.0 APGs were created.

Body System Mapping for Version 1.0 of the APGs

APG	BS	BS DESC	TYPE	APG DESCRIPTION
001	1	Skin	S	Photochemotherapy
002	1	Skin	S	Superficial needle biopsy and aspiration
003	1	Skin	S	Simple incision and drainage
004	1	Skin	S	Complex incision and drainage
005	1	Skin	S	Nail procedures
006	1	Skin	S	Simple debridement and destruction
007	1	Skin	S	Simple excision and biopsy
008	1	Skin	S	Complex excision, biopsy and debridement
010	1	Skin	S	Simple skin repair
011	1	Skin	S	Complex skin repair
012	1	Skin	S	Skin and integument graft, transfer and rearrangement
027	1	Skin	S	Simple incision and excision of breast
028	1	Skin	S	Breast reconstruction and mastectomy
631	1	Skin	M	Head and spine injury
632	1	Skin	M	Burns, and skin and soft tissue injury
856	1	Skin	M	Disease of nails
857	1	Skin	M	Chronic skin ulcer
858	1	Skin	M	Cellulitis, impetigo and lymphangitis
859	1	Skin	M	Breast diseases
860	1	Skin	M	Skin diseases
049	2	Bone,MS	S	Complex bone procedures excluding hand & foot
050	2	Bone,MS	S	Simple bone procedures excluding hand & foot
051	2	Bone,MS	S	Complex hand and foot bone procedures
052	2	Bone,MS	S	Simple hand and foot bone procedures
053	2	Bone,MS	S	Occupational therapy
054	2	Bone,MS	S	Physical therapy
056	2	Bone,MS	S	Arthroscopy
057	2	Bone,MS	S	Replacement of cast
058	2	Bone,MS	S	Splint, strapping and cast removal
059	2	Bone,MS	S	Treatment of closed fracture & dislocation of finger, toe & rib
060	2	Bone,MS	S	Treatment of closed fracture & dislocation except finger, toe & rib without manipulation
061	2	Bone,MS	S	Treatment of closed fracture & dislocation except finger, toe & rib with manipulation
062	2	Bone,MS	S	Treatment of open fracture and dislocation except face
063	2	Bone,MS	S	Bone or joint manipulation under anesthesia
067	2	Bone,MS	S	Bunion procedures
070	2	Bone,MS	S	Arthroplasty
071	2	Bone,MS	S	Hand and foot tenotomy
076	2	Bone,MS	S	Arthrocentesis and ligament or tendon injection
633	2	Bone,MS	M	Fracture, dislocation and sprain
841	2	Bone,MS	M	Back disorders
842	2	Bone,MS	M	Simple musculoskeletal diseases except back disorders

APG	BS	BS DESC	TYPE	APG DESCRIPTION
843	2	Bone,MS	M	Complex musculoskeletal diseases except back disorders
079	3	Pulmonary	S	Pulmonary test and therapy except spirometry
080	3	Pulmonary	S	Needle and catheter biopsy, aspiration, lavage and intubation
081	3	Pulmonary	S	Simple endoscopy of the upper airway
082	3	Pulmonary	S	Complex endoscopy of the upper airway
084	3	Pulmonary	S	Endoscopy of the lower airway
085	3	Pulmonary	S	Nasal cauterization and packing
088	3	Pulmonary	S	Miscellaneous sinus, tracheal and lung procedures
089	3	Pulmonary	S	Respiratory therapy
781	3	Pulmonary	M	Emphysema, chronic bronchitis and asthma age > 17
782	3	Pulmonary	M	Emphysema, chronic bronchitis and asthma age 0-17
783	3	Pulmonary	M	pneumonia
784	3	Pulmonary	M	Simple respiratory disease except emphysema, chronic bronchitis & asthma
785	3	Pulmonary	M	Complex respiratory disease except emphysema, chronic bronchitis & asthma
105	4	Cardiac	S	Exercise tolerance tests
106	4	Cardiac	S	Echocardiography
107	4	Cardiac	S	Phonocardiogram
108	4	Cardiac	S	Cardiac electrophysiologic tests
109	4	Cardiac	S	Vascular cannulation with needle and catheter
110	4	Cardiac	S	Diagnostic cardiac catheterization
111	4	Cardiac	S	Angioplasty and transcatheter procedures
112	4	Cardiac	S	Pacemaker insertion and replacement
113	4	Cardiac	S	Removal and revision of pacemaker and vascular device
114	4	Cardiac	S	Minor vascular repair and fistula construction
115	4	Cardiac	S	Secondary varicose veins and vascular injection
116	4	Cardiac	S	Vascular ligation
117	4	Cardiac	S	Cardiopulmonary resuscitation and intubation
796	4	Cardiac	M	Congestive heart failure and ischemic heart disease
797	4	Cardiac	M	Hypertension
800	4	Cardiac	M	Simple cardiovascular disease except chf, ischemic heart disease & hypertension
801	4	Cardiac	M	Complex cardiovascular disease except chf, ischemic heart disease & hypertension
131	5	Heme, Endo	S	Chemotherapy by infusion
132	5	Heme, Endo	S	Chemotherapy except by infusion
133	5	Heme, Endo	S	Phlebotomy
134	5	Heme, Endo	S	Blood and blood product exchange
135	5	Heme, Endo	S	Deep lymph structure and thyroid procedures
136	5	Heme, Endo	S	allergy tests and immunotherapy
137	5	Heme, Endo	S	transfusion
601	5	Heme, Endo	M	hematological malignancy
602	5	Heme, Endo	M	prostatic malignancy

APG	BS	BS DESC	TYPE	APG DESCRIPTION
603	5	Heme, Endo	M	Lung malignancy
604	5	Heme, Endo	M	Skin malignancy
605	5	Heme, Endo	M	Other malignancies
606	5	Heme, Endo	M	GI malignancies
607	5	Heme, Endo	M	Breast malignancies
721	5	Heme, Endo	M	Non systemic infectious diseases
725	5	Heme, Endo	M	Systemic infectious diseases
871	5	Heme, Endo	M	Diabetes
872	5	Heme, Endo	M	Obesity
873	5	Heme, Endo	M	Simple endocrine, nutritional & metabolic disease except diabetes & obesity
874	5	Heme, Endo	M	Complex endocrine, nutritional & metabolic disease except diabetes & obesity
875	5	Heme, Endo	M	Fluid and electrolyte disorders
932	5	Heme, Endo	M	Aids related complex & hiv infection with complications
933	5	Heme, Endo	M	Other simple immunologic and hematologic disease
934	5	Heme, Endo	M	Other complex immunologic and hematologic disease
935	5	Heme, Endo	M	anemia
157	6	Digestive	S	Alimentary tests and simple tube placement
158	6	Digestive	S	esophageal dilation without endoscopy
160	6	Digestive	S	Anoscopy with biopsy and diagnostic proctosigmoido-scopy
161	6	Digestive	S	Proctosigmoidoscopy with excision or biopsy
162	6	Digestive	S	Diagnostic upper gastrointestinal endoscopy
163	6	Digestive	S	Therapeutic upper gastrointestinal endoscopy
165	6	Digestive	S	Lower gastrointestinal endoscopy
166	6	Digestive	S	ercp & other miscellaneous gastrointestinal endoscopy procedures
167	6	Digestive	S	Tonsil and adenoid procedures
168	6	Digestive	S	Hernia and hydrocele procedures
170	6	Digestive	S	Simple anal and rectal procedures
171	6	Digestive	S	Complex anal and rectal procedures
172	6	Digestive	S	Peritoneal procedures and change of intra-abdominal tube
173	6	Digestive	S	Miscellaneous digestive procedures
174	6	Digestive	S	Abdominal laparoscopic organ removals
811	6	Digestive	M	Noninfectious gastroenteritis
812	6	Digestive	M	Ulcers, gastritis and esophagitis
813	6	Digestive	M	Functional gastrointestinal disease and irritable bowel syndrome
814	6	Digestive	M	Hepatobiliary disease
816	6	Digestive	M	Hemorrhoids and other anal-rectal diseases
817	6	Digestive	M	Other simple gastrointestinal diseases
818	6	Digestive	M	Other complex gastrointestinal diseases
183	7	Urologic	S	Simple urinary studies and procedures
184	7	Urologic	S	Renal extracorporeal shock wave lithotripsy

APG	BS	BS DESC	TYPE	APG DESCRIPTION
185	7	Urologic	S	Urinary catheterization and dilatation
186	7	Urologic	S	Hemodialysis
187	7	Urologic	S	Peritoneal dialysis
188	7	Urologic	S	Moderate cystourethroscopy
189	7	Urologic	S	Complex cystourethroscopy and litholapaxy
192	7	Urologic	S	Simple urethral procedures
193	7	Urologic	S	Complex urethral procedures
194	7	Urologic	S	Simple cystourethroscopy
886	7	Urologic	M	Urinary tract infection
887	7	Urologic	M	Renal failure
888	7	Urologic	M	Simple urinary disease except urinary tract infection & renal failure
889	7	Urologic	M	Complex urinary disease except urinary tract infection & renal failure
209	8	Male Rep	S	Testicular and epididymal procedures
210	8	Male Rep	S	Insertion of penile prosthesis
211	8	Male Rep	S	Complex penile procedures
212	8	Male Rep	S	Simple penile procedures
213	8	Male Rep	S	Prostate needle and punch biopsy
722	8	Male Rep	M	Sexually transmitted diseases
901	8	Male Rep	M	Benign prostatic hypertrophy
902	8	Male Rep	M	Male reproductive diseases except benign prostatic hypertrophy
235	9	Fem Rep	S	Artificial fertilization
236	9	Fem Rep	S	Procedures for pregnancy and neonatal care
237	9	Fem Rep	S	Treatment of spontaneous abortion
238	9	Fem Rep	S	Therapeutic abortion
239	9	Fem Rep	S	Vaginal delivery
240	9	Fem Rep	S	Female genital endoscopy
241	9	Fem Rep	S	Hysteroscopy
242	9	Fem Rep	S	Simple female reproductive procedures
243	9	Fem Rep	S	Dilation and curettage
244	9	Fem Rep	S	Complex female reproductive procedures
245	9	Fem Rep	S	Colposcopy
691	9	Fem Rep	M	Routine prenatal care
692	9	Fem Rep	M	Maternal antepartum complication
693	9	Fem Rep	M	Routine postpartum care
694	9	Fem Rep	M	Maternal sexualpostpartum complication
722	9	Fem Rep	M	Sexually transmitted diseases
916	9	Fem Rep	M	Female gynecologic disease
261	10	Neuro	S	Electroencephalogram
262	10	Neuro	S	Electroconvulsive therapy
263	10	Neuro	S	Nerve and muscle tests
264	10	Neuro	S	Injection of substance into spinal cord or cranial tap
266	10	Neuro	S	Nerve injection and stimulation
267	10	Neuro	S	Revision and removal of neurological device
268	10	Neuro	S	Neurostimulator and ventricular shunt implantation

APG	BS	BS DESC	TYPE	APG DESCRIPTION
270	10	Neuro	S	Nerve repair and destruction
272	10	Neuro	S	Spinal tap
736	10	Neuro	M	Tia, cva and other cerebrovascular events
737	10	Neuro	M	Headache
738	10	Neuro	M	Central nervous system diseases except tia, cva, and headache
287	11	Opth	S	Minor ophthalmological tests and procedures
288	11	Opth	S	Fitting of contact lenses
289	11	Opth	S	Simple laser eye procedures
290	11	Opth	S	Complex laser eye procedures
291	11	Opth	S	Cataract procedures
292	11	Opth	S	Simple anterior segment eye procedures
295	11	Opth	S	Moderate anterior segment eye procedures
296	11	Opth	S	Complex anterior segment eye procedures
297	11	Opth	S	Simple posterior segment eye procedures
298	11	Opth	S	Complex posterior segment eye procedures
299	11	Opth	S	Strabismus and muscle eye procedures
300	11	Opth	S	Simple repair and plastic procedures of eye
301	11	Opth	S	Complex repair and plastic procedures of eye
302	11	Opth	S	Vitrectomy
751	11	Opth	M	Cataracts
752	11	Opth	M	Refraction disorder
753	11	Opth	M	Conjunctivitis and other simple external eye inflammation
754	11	Opth	M	Eye diseases except cataract, refraction disorder & conjunctivitis
077	12	ENT	S	Speech therapy
312	12	ENT	S	Cochlear device
313	12	ENT	S	Otorhinolaryngologic function tests
318	12	ENT	S	Simple audiometry
320	12	ENT	S	Simple facial and ent procedures
321	12	ENT	S	Moderate facial and ent procedures
322	12	ENT	S	Complex facial and ent procedures
766	12	ENT	M	Dental disease
767	12	ENT	M	Acute infectious ear, nose and throat disease age > 17
768	12	ENT	M	Acute infectious ear, nose and throat disease age 0-17
769	12	ENT	M	Acute noninfectious ear, nose and throat disease
771	12	ENT	M	Hearing loss
772	12	ENT	M	Other simple ear, nose, throat and mouth diseases
773	12	ENT	M	Other complex ear, nose, throat and mouth diseases
616	13	All	M	Poisoning
634	13	All	M	Other injuries
635	13	All	M	Burns
653	13	All	M	Psychiatric medication management
655	13	All	M	Counseling and brief psychotherapy
658	13	All	M	Comprehensive psychiatric evaluation and treatment
659	13	All	M	Group psychotherapy

APG	BS	BS DESC	TYPE	APG DESCRIPTION
660	13	All	M	Partial hospitalization for mental illness
664	13	All	M	Comprehensive therapy for drug abuse
668	13	All	M	Brief psychotherapy for drug abuse
669	13	All	M	Medication management for drug abuse
670	13	All	M	Group therapy for drug abuse
671	13	All	M	Partial hospitalization for drug abuse
676	13	All	M	Neonate and congenital anomaly
827	13	All	M	Major signs, symptoms and findings
946	13	All	M	Adult medical examination
947	13	All	M	Well child care
949	13	All	M	Contraception and procreative management
950	13	All	M	Repeat prescription
951	13	All	M	Nonspecific signs & symptoms & other contacts with health services
959	13	All	M	Admitted
960	13	All	M	Died

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APPENDIX C

List of Revenue Centers Assigned to APGs

Each revenue center listed in Appendix C is used to assign an APG to a revenue trailer if there is no APG assigned based on the HCPCS code in the revenue trailer. Appendix C lists the revenue centers and the associated APGs.

RC	REVENUE CENTER DESCRIPTION	APG	APG DESCRIPTION
260	IV THERAPY-GENERAL CLASSIFICATION	372	INFUSION THERAPY EXCEPT CHEMOTHERAPY
261	IV THERAPY-INFUSION PUMP	372	INFUSION THERAPY EXCEPT CHEMOTHERAPY
269	IV THERAPY-OTHER IV THERAPY	372	INFUSION THERAPY EXCEPT CHEMOTHERAPY
310	LABORATORY PATHOLOGICAL-GENERAL CLASSIFICATION	332	SIMPLE PATHOLOGY
311	LABORATORY PATHOLOGICAL-CYTOLOGY	332	SIMPLE PATHOLOGY
312	LABORATORY PATHOLOGICAL-HISTOLOGY	332	SIMPLE PATHOLOGY
314	LABORATORY PATHOLOGICAL-BIOPSY	332	SIMPLE PATHOLOGY
319	LABORATORY PATHOLOGICAL-OTHER	332	SIMPLE PATHOLOGY
321	RADIOLOGY-DIAGNOSTIC-ANGIOCARDIOGRAPHY	076	DIAGNOSTIC CARDIAC CATHETERIZATION
323	RADIOLOGY-DIAGNOSTIC-ARTERIOGRAPHY	255	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
324	RADIOLOGY-DIAGNOSTIC-CHEST X-RAY	310	PLAIN FILM
333	RADIOLOGY-THERAPEUTIC-RADIATION THERAPY	252	RADIATION THERAPY AND HYPERTHERMIA
350	COMPUTED TOMOGRAPHIC (CT) SCAN-GENERAL CLASSIFICATION	307	COMPUTERIZED AXIAL TOMOGRAPHY
351	CT SCAN-HEAD SCAN	307	COMPUTERIZED AXIAL TOMOGRAPHY
352	CT SCAN-BODY SCAN	307	COMPUTERIZED AXIAL TOMOGRAPHY
359	CT SCAN-OTHER CT SCANS	307	COMPUTERIZED AXIAL TOMOGRAPHY
370	ANESTHESIA-GENERAL CLASSIFICATION	321	ANESTHESIA
371	ANESTHESIA-INCIDENT TO RAD	321	ANESTHESIA
372	ANESTHESIA-INCIDENT TO OTHER DIAGNOSTIC SERVICES	321	ANESTHESIA
379	ANESTHESIA-OTHER ANESTHESIA	321	ANESTHESIA
401	OTHER IMAGING SERVICES-DIAGNOSTIC MAMMOGRAPHY	308	MAMMOGRAPHY
403	OTHER IMAGING SERVICES-SCREENING MAMMOGRAPHY (EFFECTIVE 1/1/91)	308	MAMMOGRAPHY
402	OTHER IMAGING SERVICES-ULTRASOUND	305	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
404	OTHER IMAGING SERVICES-PET SCANS	306	MAGNETIC RESONANCE IMAGING
410	RESPIRATORY SERVICES-GENERAL CLASSIFICATION	057	RESPIRATORY THERAPY
412	RESPIRATORY SERVICES-INHALATION SERVICES	057	RESPIRATORY THERAPY
419	RESPIRATORY SERVICES-OTHER	057	RESPIRATORY THERAPY
420	PHYSICAL THERAPY-GENERAL CLASSIFICATION	272	PHYSICAL THERAPY
421	PHYSICAL THERAPY-VISIT CHARGE	272	PHYSICAL THERAPY
422	PHYSICAL THERAPY-HOURLY CHARGE	272	PHYSICAL THERAPY
423	PHYSICAL THERAPY-GROUP RATE	272	PHYSICAL THERAPY
424	PHYSICAL THERAPY-EVALUATION OR RE-EVALUATION	272	PHYSICAL THERAPY

RC	REVENUE CENTER DESCRIPTION	APG	APG DESCRIPTION
429	PHYSICAL THERAPY-OTHER	272	PHYSICAL THERAPY
430	OCCUPATIONAL THERAPY-GENERAL CLASSIFICATION	271	OCCUPATIONAL THERAPY
431	OCCUPATIONAL THERAPY-VISIT CHARGE	271	OCCUPATIONAL THERAPY
432	OCCUPATIONAL THERAPY-HOURLY CHARGE	271	OCCUPATIONAL THERAPY
433	OCCUPATIONAL THERAPY-GROUP RATE	271	OCCUPATIONAL THERAPY
434	OCCUPATIONAL THERAPY-EVALUATION OR RE-EVALUATION	271	OCCUPATIONAL THERAPY
439	OCCUPATIONAL THERAPY-OTHER (MAY INCLUDE RESTORATIVE THERAPY)	271	OCCUPATIONAL THERAPY
440	SPEECH-LANGUAGE PATHOLOGY-GENERAL CLASSIFICATION	273	SPEECH THERAPY
441	SPEECH-LANGUAGE PATHOLOGY-VISIT CHARGE	273	SPEECH THERAPY
442	SPEECH-LANGUAGE PATHOLOGY-HOURLY CHARGE	273	SPEECH THERAPY
443	SPEECH-LANGUAGE PATHOLOGY-GROUP RATE	273	SPEECH THERAPY
444	SPEECH-LANGUAGE PATHOLOGY-EVALUATION OR RE-EVALUATION	273	SPEECH THERAPY
449	SPEECH-LANGUAGE PATHOLOGY-OTHER	273	SPEECH THERAPY
460	PULMONARY FUNCTION-GENERAL CLASSIFICATION	371	SIMPLE PULMONARY FUNCTION TESTS
469	PULMONARY FUNCTION-OTHER	371	SIMPLE PULMONARY FUNCTION TESTS
470	AUDIOLOGY-GENERAL CLASSIFICATION	237	SIMPLE AUDIOMETRY
471	AUDIOLOGY-DIAGNOSTIC	237	SIMPLE AUDIOMETRY
472	AUDILOGY-TREATMENT	237	SIMPLE AUDIOMETRY
479	AUDIOLOGY-OTHER	237	SIMPLE AUDIOMETRY
481	CARDILOGY-CARDIAC CATH LAB	076	DIAGNOSTIC CARDIAC CATHETERIZATION
482	CARDILOGY-STRESS TEST	071	EXERCISE TOLERANCE TESTS
610	MAGNETIC RESONANCE IMAGING (MRI) - GENERAL CLASSIFICATION	306	MAGNETIC RESONANCE IMAGING
611	MRI-BRAIN (INCLUDING BRAINSTEM)	306	MAGNETIC RESONANCE IMAGING
612	MRI-SPINAL CORD (INCLUDING SPINE)	306	MAGNETIC RESONANCE IMAGING
619	MRI-OTHER	306	MAGNETIC RESONANCE IMAGING
730	EKG/ECG (ELECTROCARDIOGRAM)-GENERAL CLASSIFICATION	373	CARDIOGRAM
731	EKG/ECG (ELECTROCARDIOGRAM)-HOLTER MONITOR	378	MINOR CARDIAC AND VASCULAR TESTS
739	EKG/ECG (ELECTROCARDIOGRAM)-OTHER	373	CARDIOGRAM
740	EEG (ELECTROENCEPHALOGRAM)-GENERAL CLASSIFICATION	192	ELECTROENCEPHALOGRAM
749	EEG (ELECTROENCEPHALOGRAM)-OTHER	192	ELECTROENCEPHALOGRAM
790	LITHOTRIPSY-GENERAL CLASSIFICATION	131	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
799	LITHOTRIPSY-OTHER	131	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
820	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-GENERAL CLASSIFICATION	139	HEMODIALYSIS

RC	REVENUE CENTER DESCRIPTION	APG	APG DESCRIPTION
821	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HEMODIALYSIS/ COMPOSITE OR OTHER RATE	139	HEMODIALYSIS
822	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HOME SUPPLIES	139	HEMODIALYSIS
823	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HOME EQUIPMENT	139	HEMODIALYSIS
824	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-MAINTENANCE/ 100%	139	HEMODIALYSIS
825	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-SUPPORT SERVICES	139	HEMODIALYSIS
829	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-OTHER	139	HEMODIALYSIS
830	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- GENERAL CLASSIFICATION	140	PERITONEAL DIALYSIS
831	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- PERITONEAL/COM-POSITE OR OTHER RATE	140	PERITONEAL DIALYSIS
832	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- HOME SUPPLIES	140	PERITONEAL DIALYSIS
833	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- HOME EQUIPMENT	140	PERITONEAL DIALYSIS
834	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- MAINTENANCE/100%	140	PERITONEAL DIALYSIS
835	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- SUPPORT SERVICES	140	PERITONEAL DIALYSIS
839	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- OTHER	140	PERITONEAL DIALYSIS
840	CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)-OUTPA-TIENT-GENERAL CLASSIFICATION	140	PERITONEAL DIALYSIS
841	CAPD - OUTPATIENT - CAPD/COMPOSITE OR OTHER RATE	140	PERITONEAL DIALYSIS
842	CAPD - OUTPATIENT - HOME SUPPLIES	140	PERITONEAL DIALYSIS
843	CAPD - OUTPATIENT - HOME EQUIPMENT	140	PERITONEAL DIALYSIS
844	CAPD - OUTPATIENT - MAINTENANCE/100%	140	PERITONEAL DIALYSIS
845	CAPD - OUTPATIENT - SUPPORT SERVICES	140	PERITONEAL DIALYSIS
849	CAPD - OUTPATIENT - OTHER	140	PERITONEAL DIALYSIS
850	CONTINUOUS CYCLING PERITONEAL DIALYSIS (CCPD) - OUTPATIENT - GENERAL CLASSIFICATION	140	PERITONEAL DIALYSIS
851	CCPD - OUTPATIENT - CCPD/COMPOSITE OR OTHER RATE	140	PERITONEAL DIALYSIS
852	CCPD - OUTPATIENT - HOME SUPPLIES	140	PERITONEAL DIALYSIS
853	CCPD - OUTPATIENT - HOME EQUIPMENT	140	PERITONEAL DIALYSIS
854	CCPD - OUTPATIENT - MAINTENANCE/100%	140	PERITONEAL DIALYSIS
855	CCPD - OUTPATIENT - SUPPORT SERVICES	140	PERITONEAL DIALYSIS
859	CCPD - OUTPATIENT - OTHER	140	PERITONEAL DIALYSIS
880	MISCELLANEOUS DIALYSIS-GENERAL CLASSIFICATION	139	HEMODIALYSIS
881	MISCELLANEOUS DIALYSIS-ULTRAFILTRATION	139	HEMODIALYSIS
889	MISCELLANEOUS DIALYSIS-OTHER	139	HEMODIALYSIS

RC	REVENUE CENTER DESCRIPTION	APG	APG DESCRIPTION
901	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS- ELECTROSHOCK TREATMENT	193	ELECTROCONVULSIVE THERAPY
914	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - INDIVIDUAL THERAPY	286	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
915	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - GROUP THERAPY	289	GROUP PSYCHOTHERAPY
916	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - FAMILY THERAPY	288	FAMILY PSYCHOTHERAPY
922	OTHER DIAGNOSTIC SERVICES - ELECTROMYELOGRAM	194	NERVE AND MUSCLE TESTS
923	OTHER DIAGNOSTIC SERVICES - PAP SMEAR	333	PAP SMEARS
924	OTHER DIAGNOSTIC SERVICES-ALLERGY TEST	096	ALLERGY TESTS
944	OTHER THERAPEUTIC SERVICES-DRUG REHABILITATION	287	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY
945	OTHER THERAPEUTIC SERVICES-ALCOHOL REHABILITATION	287	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY

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APPENDIX D

Medical Visit Indicator List

In the APG analysis, any claim without a significant procedure present was considered a medical claim if it included a CPT-4 code or a revenue center listed in this appendix. CPT-4 code descriptions are copyright American Medical Association.

List of CPT-4 Codes that Indicate a Medical Visit

CODE	CODE DESCRIPTION
59400	ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, VAGINAL DELIVERY (WITH OR WITHOUT EPISIOTOMY, AND/OR FORCEPS) AND POSTPARTUM CARE
59420	ANTEPARTUM CARE ONLY (SEPARATE PROCEDURE)
59425	ANTEPARTUM CARE ONLY; 4-6 VISITS
59426	ANTEPARTUM CARE ONLY; 7 OR MORE VISITS
59430	POSTPARTUM CARE ONLY (SEPARATE PROCEDURE)
59510	ROUTINE OBSTETRIC CARE INCLUDING ANTEPARTUM CARE, CESAREAN DELIVERY, AND POSTPARTUM CARE
59800	TREATMENT OF SPONTANEOUS ABORTION, FIRST TRIMESTER COMPLETED MEDICALLY
59810	TREATMENT OF SPONTANEOUS ABORTION, SECOND TRIMESTER COMPLETED MEDICALLY
90000	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, NEW PATIENT; BRIEF SERVICE
90010	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, NEW PATIENT; LIMITED SERVICE
90015	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, NEW PATIENT; INTERMEDIATE SERVICE
90017	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, NEW PATIENT; EXTENDED SERVICE
90020	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, NEW PATIENT; COMPREHENSIVE SERVICE
90030	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, ESTABLISHED PATIENT; MINIMAL SERVICE
90040	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, ESTABLISHED PATIENT; BRIEF SERVICE
90050	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, ESTABLISHED PATIENT; LIMITED SERVICE
90060	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, ESTABLISHED PATIENT; INTERMEDIATE SERVICE
90070	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, ESTABLISHED PATIENT; EXTENDED SERVICE
90080	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICE, ESTABLISHED PATIENT; COMPREHENSIVE SERVICE
90500	EMERGENCY DEPARTMENT SERVICE, NEW PATIENT; MINIMAL SERVICE
90505	EMERGENCY DEPARTMENT SERVICE, NEW PATIENT; BRIEF SERVICE
90510	EMERGENCY DEPARTMENT SERVICE, NEW PATIENT; LIMITED SERVICE
90515	EMERGENCY DEPARTMENT SERVICE, NEW PATIENT; INTERMEDIATE SERVICE
90517	EMERGENCY DEPARTMENT SERVICE, NEW PATIENT; EXTENDED SERVICE
90520	EMERGENCY DEPARTMENT SERVICE, NEW PATIENT; COMPREHENSIVE SERVICE
90530	EMERGENCY DEPARTMENT SERVICE, ESTABLISHED PATIENT; MINIMAL SERVICE
90540	EMERGENCY DEPARTMENT SERVICE, ESTABLISHED PATIENT; BRIEF SERVICE
90550	EMERGENCY DEPARTMENT SERVICE, ESTABLISHED PATIENT; LIMITED SERVICE
90560	EMERGENCY DEPARTMENT SERVICE, ESTABLISHED PATIENT; INTERMEDIATE SERVICE
90570	EMERGENCY DEPARTMENT SERVICE, ESTABLISHED PATIENT; EXTENDED SERVICE
90580	EMERGENCY DEPARTMENT SERVICE, ESTABLISHED PATIENT; COMPREHENSIVE SERVICE
90600	INITIAL CONSULTATION; LIMITED
90605	INITIAL CONSULTATION; INTERMEDIATE
90610	INITIAL CONSULTATION; EXTENDED
90620	INITIAL CONSULTATION; COMPREHENSIVE
90630	INITIAL CONSULTATION; COMPLEX
90640	FOLLOW-UP CONSULTATION; BRIEF
90641	FOLLOW-UP CONSULTATION; LIMITED

CODE	CODE DESCRIPTION
90642	FOLLOW-UP CONSULTATION; INTERMEDIATE
90643	FOLLOW-UP CONSULTATION; COMPLEX
90651	CONFIRMATORY CONSULTATION; INTERMEDIATE
90652	CONFIRMATORY CONSULTATION; EXTENDED
90653	CONFIRMATORY CONSULTATION; COMPREHENSIVE
90654	CONFIRMATORY CONSULTATION; COMPLEX
90699	UNLISTED MEDICAL SERVICE, GENERAL
90750	INITIAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE; ADULT (AGE 18 OR OVER)
90751	INITIAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE; ADOLESCENT (AGE 12 THROUGH 17 YEARS)
90752	INITIAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE; LATE CHILDHOOD (AGE 5 THROUGH 11 YEARS)
90753	INITIAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE; EARLY CHILDHOOD (AGE 1 THROUGH 4 YEARS)
90754	INITIAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE; INFANT (AGE UNDER 1 YEAR)
90757	NEWBORN CARE, IN OTHER THAN HOSPITAL SETTING, INCLUDING PHYSICAL EXAMINATION OF BABY AND CONFERENCE(S) WITHPARENT(S)
90760	INTERVAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE, PERIODICTYPE OF EXAMINATION; ADULT (18 YEARS OR OVER)
90761	INTERVAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE, PERIODICTYPE OF EXAMINATION; ADOLESCENT (AGE 12 THROUGH 17 YEARS)
90762	INTERVAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE, PERIODICTYPE OF EXAMINATION; LATE CHILDHOOD (AGE 5 THROUGH 11 YEARS)
90763	INTERVAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE, PERIODICTYPE OF EXAMINATION; EARLY CHILDHOOD (AGE 1 THROUGH 4 YEARS)
90764	INTERVAL HISTORY AND EXAMINATION RELATED TO THE HEALTHY INDIVIDUAL, INCLUDING ANTICIPATORY GUIDANCE, PERIODICTYPE OF EXAMINATION; INFANT (AGE UNDER 1 YEAR)
90774	ADMINISTRATION AND MEDICAL INTERPRETATION OF DEVELOPMENTAL TESTS
90990	HEMODIALYSIS TRAINING AND/OR COUNSELING
90992	PERITONEAL DIALYSIS TRAINING AND/OR COUNSELING
90994	SUPERVISION OF CHRONIC AMBULATORY PERITONEAL DIALYSIS (CAPD), HOME OR OUT-PATIENT (MONTHLY)
90995	END STAGE RENAL DISEASE (ESRD) RELATED SERVICES, PER FULL MONTH
90998	END STAGE RENAL DISEASE (ESRD) RELATED SERVICES (LESS THAN FULL MONTH), PER DAY
92002	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION INTERMEDIATE, NEW PATIENT
92004	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION WITH INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAM; COMPREHENSIVE, NEW PATIENT, ONE OR MORE VISITS
92012	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION, WITH INITIATION OR CONTINUATION OF DIAGNOSTIC AND TREATMENT PROGRAM; INTERMEDIATE, ESTABLISHED PATIENT

CODE	CODE DESCRIPTION
92014	OPHTHALMOLOGICAL SERVICES: MEDICAL EXAMINATION AND EVALUATION, WITH INITIATION OR CONTINUATION OF DIAGNOSTIC AND TREATMENT PROGRAM; COMPREHENSIVE, ESTABLISHED PATIENT, ONE OR MORE VISITS
92015	DETERMINATION OF REFRACTIVE STATE
92060	SENSORIMOTOR EXAMINATION WITH MULTIPLE MEASUREMENTS OF OCULAR DEVIATION AND MEDICAL DIAGNOSTIC EVALUATION (EG, RESTRICTIVE OR PARETIC MUSCLE WITH DIPLOPIA) (SEPARATE PROCEDURE)
92081	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH MEDICAL DIAGNOSTIC EVALUATION; LIMITED EXAMINATION (EG, TANGENT SCREEN, AUTOPLOT, ARC PERIMETER, OR SINGLE STIMULUS LEVEL AUTOMATED TEST, SUCH AS OCTOPUS 3 OR 7 EQUIVALENT)
92082	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH MEDICAL DIAGNOSTIC EVALUATION; INTERMEDIATE EXAMINATION (EG, AT LEAST 2 ISOPTERS ON GOLDMANN PERIMETER, OR SEMIQUANTITATIVE, AUTOMATED SUPRATHRESHOLD SCREENING PROGRAM, HUMPHREY SUPRATHRESHOLD AUTOMATIC DIAGNOSTIC TEST, OCTOPUS PROGRAM 33)
92083	VISUAL FIELD EXAMINATION, UNILATERAL OR BILATERAL, WITH MEDICAL DIAGNOSTIC EVALUATION; EXTENDED EXAMINATION (EG, GOLDMANN VISUAL FIELDS WITH AT LEAST 3 ISOPTERS PLOTTED AND STATIC DETERMINATION WITHIN THE CENTRAL 30, OR QUANTITATIVE, AUTOMATED THRESHOLD PERIMETRY, OCTOPUS PROGRAM G-1, 32 OR 42, HUMPHREY VISUAL FIELD ANALYZER FULL THRESHOLD PROGRAMS 30-2, 24-2, OR 30/60-2)
92225	OPHTHALMOSCOPY, EXTENDED, WITH RETINAL DRAWING (EG, FOR RETINAL DETACHMENT, MELANOMA), WITH MEDICAL DIAGNOSTIC EVALUATION; INITIAL
92226	OPHTHALMOSCOPY, EXTENDED, WITH RETINAL DRAWING (EG, FOR RETINAL DETACHMENT, MELANOMA), WITH MEDICAL DIAGNOSTIC EVALUATION; SUBSEQUENT
92283	COLOR VISION EXAMINATION, EXTENDED, EG, ANOMALOSCOPE OR EQUIVALENT
92284	DARK ADAPTATION EXAMINATION, WITH MEDICAL DIAGNOSTIC EVALUATION
92506	MEDICAL EVALUATION, SPEECH, LANGUAGE AND/OR HEARING PROBLEMS
93204	PHONOCARDIOGRAM WITH OR WITHOUT ECG LEAD; INTERPRETATION AND REPORT
95105	MEDICAL CONFERENCE SERVICES (EG, USE OF MECHANICAL AND ELECTRIC DEVICES, CLIMATOTHERAPY, BREATHING EXERCISES AND/OR POSTURALDRAINAGE)
98900	MEDICAL CONFERENCE BY PHYSICIAN REGARDING MEDICAL MANAGEMENT WITH PATIENT, AND/OR RELATIVE OR GUARDIAN; APPROXIMATELY 30 MINUTES
98902	MEDICAL CONFERENCE BY PHYSICIAN REGARDING MEDICAL MANAGEMENT WITH PATIENT, AND/OR RELATIVE OR GUARDIAN; APPROXIMATELY 60 MINUTES
99025	INITIAL (NEW PATIENT) VISIT WHEN STARRED (*) SURGICAL PROCEDURE CONSTITUTES MAJOR SERVICE AT THAT VISIT
99058	OFFICE SERVICES PROVIDED ON AN EMERGENCY BASIS
99062	EMERGENCY CARE FACILITY SERVICES: WHEN THE NON-hospital based PHYSICIAN IS IN THE HOSPITAL, BUT IS INVOLVED IN PATIENT CAREELSEWHERE AND IS CALLED TO THE EMERGENCY FACILITY TO PROVIDEEMERGENCY SERVICES
99064	EMERGENCY CARE FACILITY SERVICES: WHEN THE NON-hospital based PHYSICIAN IS CALLED TO THE EMERGENCY FACILITY FROM OUTSIDE THEHOSPITAL TO PROVIDE EMERGENCY SERVICES; NOT DURING REGULAR OFFICE HOURS
99065	EMERGENCY CARE FACILITY SERVICES: WHEN THE NON-hospital based PHYSICIAN IS CALLED TO THE EMERGENCY FACILITY FROM OUTSIDE THEHOSPITAL TO PROVIDE EMERGENCY SERVICES; DURING REGULAR OFFICE HOURS
99150	PROLONGED PHYSICIAN ATTENDANCE REQUIRING PHYSICIAN DETENTION BEYOND USUAL SERVICE (EG, OPERATIVE STANDBY, MONITORING ECG, EEG, INTRATHORACIC PRESSURES, INTRAVASCULAR PRESSURES, BLOODGASES DURING SURGERY, STANDBY FOR NEWBORN CARE FOLLOWING CESAREANSECTION, OR MATERNAL-FETAL MONITORING); 30 MINUTES TO ONE HOUR

CODE	CODE DESCRIPTION
99151	PROLONGED PHYSICIAN ATTENDANCE REQUIRING PHYSICIAN DETENTION BEYOND USUAL SERVICE (EG, OPERATIVE STANDBY, MONITORING ECG, EEG, INTRATHORACIC PRESSURES, INTRAVASCULAR PRESSURES, BLOODGASES DURING SURGERY, STANDBY FOR NEWBORN CARE FOLLOWING CESAREANSECTION, OR MATERNAL-FETAL MONITORING); MORE THAN ONE HOUR
99201	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEMS ARE SELF LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 10 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99202	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 20 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99203	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99204	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 45 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99205	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 60 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99211	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. TYPICALLY, 5 MINUTES ARE SPENT PERFORMING OR SUPERVISING THESE SERVICES.
99212	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 10 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.

CODE	CODE DESCRIPTION
99213	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 15 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99214	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99215	OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 40 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99217	OBSERVATION CARE DISCHARGE DAY MANAGEMENT (THIS CODE IS TO BE UTILIZED BY THE PHYSICIAN TO REPORT ALL SERVICES PROVIDED TO A PATIENT ON DISCHARGE FROM "OBSERVATION STATUS" IF THE DISCHARGE IS ON OTHER THAN THE INITIAL DATE OF" OBSERVATION STATUS". TO REPORT SERVICES TO A PATIENT DESIGNATED AS" OBSERVATION STATUS" WHO IS DISCHARGED ON THE SAME DATE, USE ONLY THE CODES FOR INITIAL OBSERVATION SERVICES (99218-99220))
99218	INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED OR COMPREHENSIVE HISTORY; A DETAILED OR COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING THAT IS STRAIGHTFORWARD OR OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION TO "OBSERVATION STATUS" ARE OF LOW SEVERITY.
99219	INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION TO "OBSERVATION STATUS" ARE OF MODERATE SEVERITY.
99220	INITIAL OBSERVATION CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PROBLEM(S) REQUIRING ADMISSION TO "OBSERVATION STATUS" ARE OF HIGH SEVERITY.

CODE	CODE DESCRIPTION
99241	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 15 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99242	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT(S) AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99243	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 40 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99244	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 60 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99245	OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 80 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
99271	CONFIRMATORY CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR.
99272	CONFIRMATORY CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW SEVERITY.
99273	CONFIRMATORY CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY.

CODE	CODE DESCRIPTION
99274	CONFIRMATORY CONSULTATION FOR A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY.
99275	CONFIRMATORY CONSULTATION FOR A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY.
99281	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR.
99282	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY.
99283	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY.
99284	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY, AND REQUIRE URGENT EVALUATION BY THE PHYSICIAN BUT DO NOT POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION.
99285	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS WITHIN THE CONSTRAINTS IMPOSED BY THE URGENCY OF THE PATIENT'S CLINICAL CONDITION AND MENTAL STATUS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY AND POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION.
99288	PHYSICIAN DIRECTION OF EMERGENCY MEDICAL SYSTEMS (EMS) EMERGENCY CARE, ADVANCED LIFE SUPPORT ILL OR CRITICALLY INJURED PATIENT, REQUIRING THE CONSTANT ATTENDANCE OF THE PHYSICIAN; FIRST HOUR
99291	CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE CRITICALLY

CODE	CODE DESCRIPTION
99292	CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE CRITICALLY ILL OR CRITICALLY INJURED PATIENT, REQUIRING THE CONSTANT ATTENDANCE OF THE PHYSICIAN; FIRST HOUR EACH ADDITIONAL 30 MINUTES
99354	PROLONGED PHYSICIAN SERVICE IN THE OFFICE OR OTHER OUTPATIENT SETTING REQUIRING DIRECT (FACE-TO-FACE) PATIENT CONTACT BEYOND THE USUAL SERVICE (EG, PROLONGED CARE AND TREATMENT OF AN ACUTE ASTHMATIC PATIENT IN AN OUTPATIENT SETTING); FIRST HOUR
99355	PROLONGED PHYSICIAN SERVICE IN THE OFFICE OR OTHER OUTPATIENT SETTING REQUIRING DIRECT (FACE-TO-FACE) PATIENT CONTACT BEYOND THE USUAL SERVICE (EG, PROLONGED CARE AND TREATMENT OF AN ACUTE ASTHMATIC PATIENT IN AN OUTPATIENT SETTING); FIRST HOUR EACH ADDITIONAL 30 MINUTES
99358	PROLONGED EVALUATION AND MANAGEMENT SERVICE BEFORE AND/OR AFTER DIRECT (FACE-TO-FACE) PATIENT CARE (EG, REVIEW OF EXTENSIVE RECORDS AND TESTS, COMMUNICATION WITH OTHER PROFESSIONALS AND/OR THE PATIENT/FAMILY); FIRST HOUR
99359	PROLONGED EVALUATION AND MANAGEMENT SERVICE BEFORE AND/OR AFTER DIRECT (FACE-TO-FACE) PATIENT CARE (EG, REVIEW OF EXTENSIVE RECORDS AND TESTS, COMMUNICATION WITH OTHER PROFESSIONALS AND/OR THE PATIENT/FAMILY); FIRST HOUR EACH ADDITIONAL 30 MINUTES
99381	INITIAL PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; INFANT (AGE UNDER 1 YEAR)
99382	INITIAL PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; INFANT (AGE UNDER 1 YEAR) EARLY CHILDHOOD (AGE 1 THROUGH 4 YEARS)
99383	INITIAL PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; INFANT (AGE UNDER 1 YEAR) LATE CHILDHOOD (AGE 5 THROUGH 11 YEARS)
99384	INITIAL PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; INFANT (AGE UNDER 1 YEAR) ADOLESCENT (AGE 12 THROUGH 17 YEARS)
99385	INITIAL PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; INFANT (AGE UNDER 1 YEAR) 18-39 YEARS
99386	INITIAL PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; INFANT (AGE UNDER 1 YEAR) 40-64 YEARS
99387	INITIAL PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, A COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, NEW PATIENT; INFANT (AGE UNDER 1 YEAR) 65 YEARS AND OVER

CODE	CODE DESCRIPTION
99391	PERIODIC PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; INFANT (AGE UNDER 1 YEAR)
99392	PERIODIC PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; INFANT (AGE UNDER 1 YEAR) EARLY CHILDHOOD (AGE 1 THROUGH 4 YEARS)
99393	PERIODIC PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; INFANT (AGE UNDER 1 YEAR) LATE CHILDHOOD (AGE 5 THROUGH 11 YEARS)
99394	PERIODIC PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; INFANT (AGE UNDER 1 YEAR) ADOLESCENT (AGE 12 THROUGH 17 YEARS)
99395	PERIODIC PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; INFANT (AGE UNDER 1 YEAR) 18-39 YEARS
99396	PERIODIC PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; INFANT (AGE UNDER 1 YEAR) 40-64 YEARS
99397	PERIODIC PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING A COMPREHENSIVE HISTORY, COMPREHENSIVE EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FACTOR REDUCTION INTERVENTIONS, AND THE ORDERING OF APPROPRIATE LABORATORY/DIAGNOSTIC PROCEDURES, ESTABLISHED PATIENT; INFANT (AGE UNDER 1 YEAR) 65 YEARS AND OVER
99401	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES
99402	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES APPROXIMATELY 30 MINUTES
99403	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES APPROXIMATELY 45 MINUTES
99404	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES APPROXIMATELY 60 MINUTES
99411	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES
99412	PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES APPROXIMATELY 60 MINUTES

CODE	CODE DESCRIPTION
99420	ADMINISTRATION AND INTERPRETATION OF HEALTH RISK ASSESSMENT INSTRUMENT (EG, HEALTH HAZARD APPRAISAL)
99429	UNLISTED PREVENTIVE MEDICINE SERVICE
99431	HISTORY AND EXAMINATION OF THE NORMAL NEWBORN INFANT, INITIATION OF DIAGNOSTIC AND TREATMENT PROGRAMS AND PREPARATION OF HOSPITAL RECORDS. (THIS CODE SHOULD ALSO BE USED FOR BIRTHING ROOM DELIVERIES.)
99432	NORMAL NEWBORN CARE IN OTHER THAN HOSPITAL OR BIRTHING ROOM SETTING, INCLUDING PHYSICAL EXAMINATION OF BABY AND CONFERENCE(S) WITH PARENT(S)
99499	UNLISTED EVALUATION AND MANAGEMENT SERVICE
99456	WORK RELATED OR MEDICAL DISABILITY EXAMINATION BY OTHER THAN THE TREATING PHYSICIAN THAT INCLUDES: COMPLETION OF A MEDICAL HISTORY COMMENSURATE WITH THE PATIENT'S CONDITION; PERFORMANCE OF AN EXAMINATION COMMENSURATE WITH THE PATIENT'S CONDITION; FORMULATION OF A DIAGNOSIS, ASSESSMENT OF CAPABILITIES AND STABILITY, AND CALCULATION OF IMPAIRMENT; DEVELOPMENT OF FUTURE MEDICAL TREATMENT PLAN; AND COMPLETION OF NECESSARY DOCUMENTATION/CERTIFICATES AND REPORT.
99455	WORK RELATED OR MEDICAL DISABILITY EXAMINATION BY THE TREATING PHYSICIAN THAT INCLUDES: COMPLETION OF A MEDICAL HISTORY COMMENSURATE WITH THE PATIENT'S CONDITION; PERFORMANCE OF AN EXAMINATION COMMENSURATE WITH THE PATIENT'S CONDITION; FORMULATION OF A DIAGNOSIS, ASSESSMENT OF CAPABILITIES AND STABILITY, AND CALCULATION OF IMPAIRMENT; DEVELOPMENT OF FUTURE MEDICAL TREATMENT PLAN; AND COMPLETION OF NECESSARY DOCUMENTATION/CERTIFICATES AND REPORT.
99450	BASIC LIFE AND/OR DISABILITY EXAMINATION THAT INCLUDES: MEASUREMENT OF HEIGHT, WEIGHT AND BLOOD PRESSURE; COMPLETION OF A MEDICAL HISTORY FOLLOWING A LIFE INSURANCE PRO FORMA; COLLECTION OF BLOOD SAMPLE AND/OR URINALYSIS COMPLYING WITH "CHAIN OF CUSTODY" PROTOCOLS; AND COMPLETION OF NECESSARY DOCUMENTATION/CERTIFICATES.

List of Revenue Centers that Indicate a Medical Visit

RC	RC DESCRIPTION
280	ONCOLOGY-GENERAL CLASSIFICATION
289	ONCOLOGY-OTHER ONCOLOGY
450	EMERGENCY ROOM-GENERAL CLASSIFICATION
459	EMERGENCY ROOM-OTHER
510	CLINIC - GENERAL CLASSIFICATION
511	CLINIC - CHRONIC PAIN CENTER
512	CLINIC - DENTAL CENTER
513	CLINIC - PSYCHIATRIC
514	CLINIC - OB-GYN
515	CLINIC - PEDIATRIC
519	CLINIC - OTHER
520	FREE-STANDING CLINIC GENERAL CLSFCTN
521	FREE-STANDING CLINIC-RURAL HEALTH- CLINIC
522	FREE-STANDING CLINIC-RURAL HEALTH-HOME
523	FREE-STANDING CLINIC-FAMILY PRACTICE
529	FREE-STANDING CLINIC-OTHER
530	OSTEOPATHIC SERVICES-GENERAL CLASSIFICATION
531	OSTEOPATHIC SERVICES-OSTEOPATHIC THERAPY
539	OSTEOPATHIC SERVICES-OTHER
910	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - GENERAL CLASSIFICATION
911	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - REHABILITATION
912	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - DAY CARE
913	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - NIGHT CARE
914	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - INDIVIDUAL THERAPY
915	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - GROUP THERAPY
916	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - FAMILY THERAPY
917	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - BIOFEEDBACK
918	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - TESTING
919	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - OTHER
944	OTHER THERAPEUTIC SERVICES-DRUG REHABILITATION
945	OTHER THERAPEUTIC SERVICES-ALCOHOL REHABILITATION

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APPENDIX E

Data Edits

The following is a list of the edits performed on the visit records during the edit step of processing. While not all of the edits listed here are considered fatal, all edits are identified in this listing for completeness. Fatal errors are identified as such. A fatal error resulted in the exclusion of the entire claim and any associated claims (claims for services incurred by the same individual, for the same provider, and on the same day) from the analysis.

The edit numbering scheme reflects the order in which edits were implemented. Some of the edit numbers are no longer in use but have been retained to make the numbering used in this document consistent with processing documentation. Some of the edits use the Revenue Center Allocation (RCA) table. The RCA table is explained in Appendix F.

0. *Revenue Center Not Found in RCA Table.*

   Fatal. For revenue trailers without an assigned APG, the value of the revenue center code is used to edit the claim and to determine whether or not the revenue trailer charge is included in the primary APG. The Revenue Center Allocation (RCA), the process which reviews APG assignment and ensures data quality, specifies the action associated with each revenue center. An error occurs when the value of the revenue center code(s), which has no APG assigned in the same revenue trailer, is not found in the RCA table.

1. *CPT-4 Code Required in RCA.*

   Fatal. This edit is invoked when any of the following conditions exist:

   1. When the RCA action is "Require CPT, Assign APG, Error if not Significant Procedure (SP)", but there is no significant procedure found.
   2. When the RCA action is "Require CPT", but there is no CPT-4 code in the revenue trailer.

2. *Revenue Center Considered an Error.*

   Fatal. When the RCA action is "Error". For example, this occurs with inpatient data because it is non-groupable.

3. *Revenue Center Requires a Significant Procedure (SP) Number.*

   Fatal. When the RCA action is "Allocate SP only", but there is no significant procedure found indicating a data consistency problem.

4. *No Longer In Use.*

5. *No Longer In Use.*

6. *No Longer In Use.*

7. *No Longer In Use.*

8. *No Significant Procedure, No Ancillary, No Medical Visit Indicator.*

   Fatal. This edit occurs when the record type can not be determined, i.e., there is no assigned APG.

   1. There is no significant procedure found in the revenue trailers.
   2. There is neither MVCPT nor medical visit RC code (MVRC) found in

the revenue trailers.

3. There is no ancillary service performed.
4. There is no medical APG assigned when either MVCPT or MVRC found.

9. *No Direct Charge.*

   Fatal. For a claim with a single or multiple significant procedure or medical visit, but there is no direct charge amount.

10. *Any Revenue Trailer with Charge Equal to Zero.*

    Non-fatal. This edit shows how many revenue trailers have no charge amount.

11. *Total Charge Differs Significantly from Sum of Revenue Trailer Charges.*

    Fatal. This edit is invoked if there is a difference between the grand total stored in the revenue trailer with revenue center code "001" and the total charge amount calculated in the edits process. If the difference is greater than what would be expected from rounding, the claim is considered suspect.

12. *Non-packaged Incidental.*

    Fatal. An incidental procedure should not be assigned into a revenue trailer unless it is packaged in order to have its charge be included in the primary APG. This edit should never be invoked and is included only for completeness.

13. *Ancillary Rectype with Packaged Incidental APG.*

    Fatal. An ancillary service performed claim record should not have any revenue trailer which has packaged incidental procedure assigned to it. Incidental procedures on an ancillary only claim are considered an error.

14. *Blank Revenue Center Code.*

    Fatal. Empty revenue center found in any revenue trailer.

15. *Invalid Revenue Center Code.*

    Fatal. Invalid revenue center found in any revenue trailer.

16. *Revenue Center Indicating a Professional Service.*

    Non-fatal. Any of the following revenue center codes, which indicate a professional service, is found in any revenue trailer:

RC Code	Description
960	PROFESSIONAL FEES-GENERAL CLASSIFICATION
961	PROFESSIONAL FEES-PSYCHIATRIC
962	PROFESSIONAL FEES-OPHTHALMOLOGY
963	PROFESSIONAL FEES-ANESTHESIOLOGIST (MD)
964	PROFESSIONAL FEES-ANESTHETIST (CRNA)
969	PROFESSIONAL FEES-OTHER
971	PROFESSIONAL FEES-LABORATORY

RC Code	Description
972	PROFESSIONAL FEES-RADIOLOGY-DIAGNOSTIC
973	PROFESSIONAL FEES-RADIOLOGY-THERAPEUTIC
794	PROFESSIONAL FEES-NUCLEAR MEDICINE
975	PROFESSIONAL FEES-OPERATING ROOM
976	PROFESSIONAL FEES-RESPIRATORY THERAPY
977	PROFESSIONAL FEES-PHYSICAL THERAPY
978	PROFESSIONAL FEES-OCCUPATIONAL THERAPY
979	PROFESSIONAL FEES-SPEECH PATHOLOGY
981	PROFESSIONAL FEES-EMERGENCY ROOM
982	PROFESSIONAL FEES-OUTPATIENT SERVICES
983	PROFESSIONAL FEES-CLINIC
984	PROFESSIONAL FEES-MEDICAL SOCIAL SERVICES
985	PROFESSIONAL FEES-EKG
986	PROFESSIONAL FEES-EEG
987	PROFESSIONAL FEES-HOSPITAL VISIT
988	PROFESSIONAL FEES-CONSULTATION
989	PROFESSIONAL FEES-PRIVATE DUTY NURSE

17. *Invalid HCPCS Code.*

    Fatal. Invalid HCPCS code found in any revenue trailer.

18. *Invalid CPT-4 Code.*

    Fatal. Invalid CPT-4 code found in any revenue trailer.

19. *Blank HCPCS Code.*

    Non-fatal. Empty HCPCS code found in any revenue trailer without a revenue center code of 001. This is not considered an error but is identified during the edit processing.

20. *No Reported HCPCS Code.*

    Fatal. Any of the non-reported HCPCS code found in any revenue trailer.

21. *HCPCS Code Indicating a Noncovered Service.*

    Fatal. Any of the HCPCS codes indicating a noncovered service found in any revenue trailer:

HCPCS Code	Description
15775	HAIR TRANSPLANT PUNCH GRAFTS
15776	HAIR TRANSPLANT PUNCH GRAFTS
15876	SUCTION ASSISTED LIPECTOMY
15877	SUCTION ASSISTED LIPECTOMY
15878	SUCTION ASSISTED LIPECTOMY
15879	SUCTION ASSISTED LIPECTOMY
36468	INJECTION(S);SPIDER VEINS
36469	INJECTION(S);SPIDER VEINS
44131	INTESTINAL BYPASS

HCPCS Code	Description
47135	TRANSPLANTATION OF LIVER
48160	PANCREAS REMOVAL, TRANSPLANT
55250	REMOVAL OF SPERM DUCT(S)
55450	LIGATION OF SPERM DUCT
55970	SEX TRANSFORMATION, M TO F
55980	SEX TRANSFORMATION, F TO M
57170	FITTING OF DIAPHRAGM/CAP
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
58600	DIVISION OF FALLOPIAN TUBE
58605	DIVISION OF FALLOPIAN TUBE
58611	LIGATE OVIDUCT(S)
58615	OCCLUDE FALLOPIAN TUBE(S)
58982	LAPAROSCOPY; TUBAL CAUTERY
58983	LAPAROSCOPY; TUBAL BLOCK
65760	REVISION OF CORNEA
65765	REVISION OF CORNEA
65767	CORNEAL TISSUE TRANSPLANT
65771	RADIAL KERATOTOMY
69090	PIERCE EARLOBES
78351	BONE MINERAL CONTENT STUDY
90846	SPECIAL FAMILY THERAPY

22. *No Medical APG Assigned to Medical Visit.*

    Fatal. MVCPT or MVRC exists and there is no medical APG assigned.

23. *Bad Medical APG 997.*

    Fatal. Medical APG has been coded as 997 because of an ICD-9-CM "E" code (accident or poisoning).

24. *Bad Medical APG 998.*

    Fatal. Medical APG has been coded as 998, unacceptable diagnosis, requires procedure.

25. *Bad Medical APG 999.*

    Fatal. Medical APG has been coded as 999, invalid HCPCS code.

26. *Procedure Error APG 992.*

    Fatal. A non-mappable HCPCS Code has resulted in the assignment of APG 992.

27. *Medical Error APG 996.*

    Fatal. The reason for visit or the diagnosis is invalid and resulted in the assignment of APG 996.

28. *Autopsy APG 994.*

    Fatal. APG code 994 (autopsy) is found in any revenue trailer.

29. *APG Indicating Non-covered Care, Settings, or Services.*

    Fatal. APG code 995, indicating non-covered care, settings or services, is found in any revenue trailer.

30. *Inpatient Services APG 993.*

    Fatal. APG code 993, indicating an inpatient service, is found in any revenue trailer.

31. *Invalid Procedure APG 999.*

    Fatal. APG code 999, Invalid Procedure, is found in any revenue trailer.

32. *Invalid AGE < 0 or > 124.*

    Fatal. The difference between birthday and admitting date is less than zero or greater than 124.

33. *AGE Conflict with DX.*

    The diagnosis code (DX) is inconsistent with the patient's age. The age of the patient is calculated from the difference between patient's birthday and the admitting date.

34. *Invalid ICD-9-CM DX.*

    Fatal. All ICD-9-CM diagnosis codes on the record are required to be valid.

35. *Unknown Sex Code 0.*

    Fatal. Unknown sex code 0 is found or an inconsistency has occurred on sex code between claims.

36. *Invalid Sex Code Not 0,1,2.*

    Fatal. Either blank or invalid code is found in sex code field.

37. *Sex Conflict with DX.*

    Fatal. The diagnosis code (DX) is not consistent with the patient's sex.

38. *Sex Conflict with Procedure Code.*

    Fatal. The procedure is not consistent with the patient's sex.

39. *Invalid Dates of Service ADATE > DDATE*

    Fatal. Discharge date should not occur before the admitting date.

40. *Professional Value Code 05*

    Fatal. If any of the value codes in value group is coded as "05", then this edit would be turned on to indicate a professional service has been performed.

41. *Financial Data from Provider Is Unreliable.*

    Fatal. Certain provider numbers are considered to have unreliable cost or charge data because they were all inclusive rate providers or Indian Health Service Hospitals and were, therefore, removed from the analysis.

42. *Possible duplicate claim.*

    Fatal.

43. RC Edits 0 Error.

Fatal. The following HCPCS codes are invalid for the following bill types because other HCPCS codes should be used to describe these services:

Bill Types	Description
13X	Hospital Outpatient
14X	Hospital Other Part B
71X	Clinic Inpatient (with provider numbers in 3975-3999)
83X	Special or ASC (Ambulatory Surgical Center) Outpatient

HCPCS Code	Description
90100	HOME VISIT, NEW, BRIEF
90110	HOME VISIT, NEW, LIMITED
90115	HOME VISIT, NEW, INTERMEDIATE
90117	HOME VISIT, NEW, EXTENDED
90130	HOME VISIT, MINIMAL
90140	HOME VISIT, BRIEF
90150	HOME VISIT, LIMITED
90160	HOME VISIT, INTERMEDIATE
90170	HOME VISIT, EXTENDED
90200	HOSPITAL CARE, NEW, BRIEF
90215	HOSPITAL CARE, NEW, INTERMEDIATE
90220	HOSPITAL CARE, NEW, COMPREHENSIVE
90225	HOSPITAL CARE, NEW, NEWBORN
90240	HOSPITAL VISIT, BRIEF
90250	HOSPITAL VISIT, LIMITED
90260	HOSPITAL VISIT, INTERMEDIATE
90270	HOSPITAL VISIT, EXTENDED
90280	HOSPITAL VISIT, COMPREHENSIVE
90282	NORMAL NEWBORN CARE, HOSPITAL
90292	HOSPITAL DISCHARGE DAY
90300	CARE FACILITY VISIT, BRIEF
90315	CARE FACILITY VISIT, INTERMEDIATE
90320	CARE FACILITY VISIT, COMPREHENSIVE
90340	CARE FACILITY VISIT, BRIEF
90350	CARE FACILITY VISIT, LIMITED
90360	CARE FACILITY VISIT, INTERMEDIATE
90370	CARE FACILITY VISIT, EXTENDED
90400	CARE FACILITY VISIT, BRIEF
90410	CARE FACILITY VISIT, LIMITED
90415	CARE FACILITY VISIT, INTERMEDIATE
90420	CARE FACILITY VISIT, COMPREHENSIVE
90430	CARE FACILITY VISIT, MINIMAL
90440	CARE FACILITY VISIT, BRIEF
90450	CARE FACILITY VISIT, LIMITED

HCPCS Code	Description
90460	CARE FACILITY VISIT, INTERMEDIATE
90470	CARE FACILITY VISIT, EXTENDED
90590	ADVANCED LIFE SUPPORT
90699	GENERAL MEDICAL SERVICE
90750	PREVENTIVE MEDICINE, ADULT
90751	PREVENTIVE MEDICINE, 12-17
90752	PREVENTIVE MEDICINE, 5-11
90753	PREVENTIVE MEDICINE, 1-4
90754	PREVENTIVE MEDICINE, INFANT
90755	INFANT CARE TO AGE ONE YEAR
90757	NEWBORN CARE NOT IN HOSPITAL
90760	PREVENTIVE MEDICINE, ADULT
90761	PREVENTIVE MEDICINE, 12-17
90762	PREVENTIVE MEDICINE, 5-11
90763	PREVENTIVE MEDICINE, 1-4
90764	PREVENTIVE MEDICINE, INFANT
90774	DEVELOPMENT EVALUATION TESTS
90778	BREATH RECORDING, INFANT
90780	IV INFUSION THERAPY, 1 HOUR
90781	IV INFUSION, ADDITIONAL HOUR
90935	HEMODIALYSIS, ONE EVALUATION
90937	HEMODIALYSIS, REPEATED EVALUATION
90945	DIALYSIS, ONE EVALUATION
90947	DIALYSIS, REPEATED EVALUATION
90989	DIALYSIS TRAINING/COMPLETE
90993	DIALYSIS TRAINING/INCOMPLETE
90995	ESRD RELATED SERVICES,MONTH
90997	HEMOPERFUSION
90998	ESRD RELATED SERVICES,DAY
90999	DIALYSIS PROCEDURE
93000	ELECTROCARDIOGRAM, COMPLETE
93010	ELECTROCARDIOGRAM REPORT
93014	REPORT ON TRANSMITTED ECG
93015	CARDIOVASCULAR STRESS TEST
93018	CARDIOVASCULAR STRESS TEST
93040	RHYTHM ECG WITH REPORT
93042	RHYTHM ECG, REPORT
93201	PHONOCARDIOGRAM & ECG LEAD
93204	PHONOCARDIOGRAM & ECG LEAD
93205	SPECIAL PHONOCARDIOGRAM
93209	SPECIAL PHONOCARDIOGRAM
93220	VECTORCARDIOGRAM
93222	VECTORCARDIOGRAM REPORT
93224	ECG MONITOR/REPORT, 24 HRS
93227	ECG MONITOR/REVIEW, 24 HRS
93230	ECG MONITOR/REPORT, 24 HRS
93233	ECG MONITOR/REVIEW, 24 HRS

HCPCS Code	Description
93235	ECG MONITOR/REPORT, 24 HRS
93237	ECG MONITOR/REVIEW, 24 HRS
96400	CHEMOTHERAPY, (SC)/(IM)
96408	CHEMOTHERAPY, PUSH TECHNIQUE
96410	CHEMOTHERAPY, INFUSION METHOD
96412	CHEMOTHERAPY, INFUSION METHOD
96414	CHEMOTHERAPY, INFUSION METHOD
96420	CHEMOTHERAPY, PUSH TECHNIQUE
96422	CHEMOTHERAPY, INFUSION METHOD
96423	CHEMOTHERAPY, INFUSION METHOD
96425	CHEMOTHERAPY, INFUSION METHOD
96440	CHEMOTHERAPY, INTRACAVITARY
96445	CHEMOTHERAPY, INTRACAVITARY
96450	CHEMOTHERAPY, INTO CNS
96520	PUMP REFILLING, MAINTENANCE
96530	PUMP REFILLING, MAINTENANCE
96545	PROVIDE CHEMOTHERAPY AGENT
96549	CHEMOTHERAPY, UNSPECIFIED
97010	HOT OR COLD PACKS THERAPY
97012	MECHANICAL TRACTION THERAPY
97014	ELECTRIC STIMULATION THERAPY
97016	VASOPNEUMATIC DEVICE THERAPY
97018	PARAFFIN BATH THERAPY
997020	MICROWAVE THERAPY
97022	WHIRLPOOL THERAPY
97024	DIATHERMY TREATMENT
97026	INFRARED THERAPY
97028	ULTRAVIOLET THERAPY
97039	PHYSICAL THERAPY TREATMENT
97110	THERAPEUTIC EXERCISES 30 MIN
97112	NEUROMUSCULAR REEDUCATION
97114	FUNCTIONAL ACTIVITY THERAPY
97116	GAIT TRAINING THERAPY
97118	MANUAL ELECTRIC STIMULATION
97120	ELECTRIC CURRENT THERAPY
97122	MANUAL TRACTION THERAPY
97124	MASSAGE THERAPY
97126	CONTRAST BATHS THERAPY
97128	ULTRASOUND THERAPY
97139	PHYSICAL MEDICINE PROCEDURE
97145	EXTENDED PHYSIOTHERAPY
97220	HYDROTHERAPY
97221	EXTENDED HYDROTHERAPY
97240	HYDROTHERAPY
97241	EXTENDED HYDROTHERAPY
97260	REGIONAL MANIPULATION
97261	SUPPLEMENTAL MANIPULATIONS

HCPCS Code	Description
97500	ORTHOTICS TRAINING
97501	SUPPLEMENTAL TRAINING
97520	PROSTHETIC TRAINING
97521	SUPPLEMENTAL TRAINING
97530	KINETIC THERAPY
97531	ADDED KINETIC THERAPY
97540	TRAINING FOR DAILY LIVING
97541	SUPPLEMENTAL TRAINING
97700	TRAINING CHECKOUT
97701	SUPPLEMENTAL CHECKOUT
97720	EXTREMITY TESTING
97721	SUPPLEMENTAL LIMB TESTING
97752	MUSCLE TESTING WITH EXERCISE
97799	PHYSICAL MEDICINE PROCEDURE
998900	CONFERENCE WITH PHYSICIAN
98902	CONFERENCE WITH PHYSICIAN
98910	CONFERENCE WITH PHYSICIAN
98912	CONFERENCE WITH PHYSICIAN
98920	PHYSICIAN PHONE CONSULT
98921	PHYSICIAN PHONE CONSULT
98922	PHYSICIAN PHONE CONSULT
99000	SPECIMEN HANDLING
99001	SPECIMEN HANDLING
99002	DEVICE HANDLING
99024	POST-OP FOLLOW-UP VISIT
99025	INITIAL SURGICAL EVALUATION
99050	POST-OP FOLLOW-UP VISIT
99052	MEDICAL SERVICES AT NIGHT
99054	MEDICAL SERVICES, UNUSUAL HRS
99056	NON-OFFICE MEDICAL SERVICES
99058	OFFICE EMERGENCY CARE
99062	EMERGENCY CARE SERVICES
99064	EMERGENCY CARE SERVICES
99065	EMERGENCY CARE SERVICES
99070	SPECIAL SUPPLIES
99071	PATIENT EDUCATION MATERIALS
99075	MEDICAL TESTIMONY
99078	GROUP HEALTH EDUCATION
99080	SPECIAL REPORTS OR FORMS
99082	UNUSUAL PHYSICIAN TRAVEL
99090	COMPUTER DATA ANALYSIS
99100	SPECIAL ANESTHESIA SERVICE
99116	ANESTHESIA WITH HYPOTHERMIA
99135	SPECIAL ANESTHESIA PROCEDURE
99140	EMERGENCY ANESTHESIA
99150	PROLONGED MD ATTENDANCE
99151	PROLONGED MD ATTENDANCE

HCPCS Code	Description
99152	NEWBORN RESUSCITATION
99160	CRITICAL CARE, FIRST HOUR
99162	CRITICAL CARE, ADDED 30 MIN
99171	CRITICAL CARE, FOLLOW-UP
99172	CRITICAL CARE, FOLLOW-UP
99173	CRITICAL CARE, FOLLOW-UP
99174	CRITICAL CARE, FOLLOW-UP
99190	SPECIAL PUMP SERVICES
99191	SPECIAL PUMP SERVICES
99192	SPECIAL PUMP SERVICES
99199	SPECIAL SERVICE OR REPORT

The following edits, 44 - 58, are effective for outpatient bill types: 13X, 14X, 83X, 71X with provider numbers in the 3975-3999 range for dates of service effective on or after Oct 1, 1991:

44. RC Edits 1 Error.

Fatal. If one or more of the following revenue codes are present, then a HCPCS code must be present:

RC Code	Description
240	ALL INCLUSIVE ANCILLARY-GENERAL CLASSIFICATION
249	ALL INCLUSIVE ANCILLARY-OTHER INCLUSIVE ANCILLARY
274	MED/SURG SUPPLIES-PROSTHETIC / ORTHOTIC DEVICES
280	ONCOLOGY-GENERAL CLASSIFICATION
289	ONCOLOGY-OTHER ONCOLOGY
331	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY- INJECTED
332	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY- ORAL
335	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-IV
410	RESPIRATORY SERVICES-GENERAL CLASSIFICATION
412	RESPIRATORY SERVICES-INHALATION SERVICES
413	RESPIRATORY SERVICES-HYPERBARIC OXYGEN THERAPY
419	RESPIRATORY SERVICES-OTHER
420	PHYSICAL THERAPY-GENERAL CLASSIFICATION
421	PHYSICAL THERAPY-VISIT CHARGE
422	PHYSICAL THERAPY-HOURLY CHARGE
423	PHYSICAL THERAPY-GROUP RATE
424	PHYSICAL THERAPY-EVALUATION OR RE-EVALUATION
429	PHYSICAL THERAPY-OTHER
430	OCCUPATIONAL THERAPY-GENERAL CLASSIFICATION
431	OCCUPATIONAL THERAPY-VISIT CHARGE
432	OCCUPATIONAL THERAPY-HOURLY CHARGE
433	OCCUPATIONAL THERAPY-GROUP RATE
434	OCCUPATIONAL THERAPY-EVALUATION OR RE-EVALUATION
439	OCC THERAPY-OTHER (MAY INCLUDE RESTORATIVE THERAPY)
440	SPEECH-LANGUAGE PATHOLOGY-GENERAL CLASSIFICATION
441	SPEECH-LANGUAGE PATHOLOGY-VISIT CHARGE

RC Code	Description
442	SPEECH-LANGUAGE PATHOLOGY-HOURLY CHARGE
443	SPEECH-LANGUAGE PATHOLOGY-GROUP RATE
444	SPEECH-LANGUAGE PATHOLOGY-EVALUATION OR RE-EVALUATION
449	SPEECH-LANGUAGE PATHOLOGY-OTHER
450	EMERGENCY ROOM-GENERAL CLASSIFICATION
459	EMERGENCY ROOM-OTHER
460	PULMONARY FUNCTION-GENERAL CLASSIFICATION
469	PULMONARY FUNCTION-OTHER
470	AUDIOLOGY-GENERAL CLASSIFICATION
471	AUDIOLOGY-DIAGNOSTIC
472	AUDIOLOGY-TREATMENT
479	AUDIOLOGY-OTHER
480	CARDIOLOGY-GENERAL CLASSIFICATION
481	CARDIOLOGY-CARDIAC CATH LAB
482	CARDIOLOGY-STRESS TEST
489	CARDIOLOGY-OTHER
500	OUTPATIENT SERVICES-GENERAL CLASSIFICATION
509	OUTPATIENT SERVICES-OTHER
510	CLINIC-GENERAL CLASSIFICATION
511	CLINIC-CHRONIC PAIN CENTER
512	CLINIC-DENTAL CENTER
513	CLINIC-PSYCHIATRIC
514	CLINIC-OB-GYN
515	CLINIC-PEDIATRIC
519	CLINIC-OTHER
520	FREE-STANDING CLINIC GENERAL CLASSIFICATION
521	FREE-STANDING CLINIC-RURAL HEALTH- CLINIC
522	FREE-STANDING CLINIC-RURAL HEALTH-HOME
523	FREE-STANDING CLINIC-FAMILY PRACTICE
529	FREE-STANDING CLINIC-OTHER
530	OSTEOPATHIC SERVICES-GENERAL CLASSIFICATION
531	OSTEOPATHIC SERVICES-OSTEOPATHIC THERAPY
539	OSTEOPATHIC SERVICES-OTHER
636	DRUGS-REQUIRING DETAILED CODING
750	GASTRO-INTESTINAL SERVICES-GENERAL CLASSIFICATION
759	GASTRO-INTESTINAL SERVICES-OTHER
760	TREATMENT OR OBSERVATION ROOM-GENERAL CLASSIFICATION
761	TREATMENT OR OBSERVATION ROOM-TREATMENT ROOM
762	TREATMENT OR OBSERVATION ROOM-OBSERVATION ROOM
769	TREAT OR OBS ROOM-OTHER TREATMENT/OBSERVATION ROOM
900	PSYCHIATRIC/PSYCHOLOGICAL TREAT-GENERAL CLASS
901	PSYCHIATRIC/PSYCHOLOGICAL TREAT-ELECTROSHOCK TREATMENT
902	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-MILIEU THERAPY
903	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-PLAY THERAPY
909	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-OTHER
910	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-GENERAL CLASS
911	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-REHABILITATION

RC Code	Description
912	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-DAY CARE
913	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-NIGHT CARE
914	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-INDIVIDUAL THERAPY
915	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-GROUP THERAPY
916	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-FAMILY THERAPY
917	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-BIOFEEDBACK
918	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-TESTING
919	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-OTHER
920	OTHER DIAGNOSTIC SERVICES-GENERAL CLASSIFICATION
921	OTHER DIAGNOSTIC SERVICES-PERIPHERAL VASCULAR LAB
922	OTHER DIAGNOSTIC SERVICES-ELECTROMYELOGRAM
923	OTHER DIAGNOSTIC SERVICES-PAP SMEAR
924	OTHER DIAGNOSTIC SERVICES-ALLERGY TEST
925	OTHER DIAGNOSTIC SERVICES-PREGNANCY TEST
929	OTHER DIAGNOSTIC SERVICES-OTHER
940	OTHER THERAPEUTIC SERVICES-GENERAL CLASSIFICATION
941	OTHER THERAPEUTIC SERVICES-RECREATIONAL THERAPY
943	OTHER THERAPEUTIC SERVICES-CARDIAC REHABILITATION
944	OTHER THERAPEUTIC SERVICES-DRUG REHABILITATION
945	OTHER THERAPEUTIC SERVICES-ALCOHOL REHABILITATION
949	OTHER THERAPEUTIC SERVICES-OTHER

45. RC Edits 2 Error

Fatal. If a revenue code(s) of 28X, 331, 332, or 335 is present then at least one of these three HCPCS codes, Q0083, Q0084, or Q0085, must be present:

RC Code	Description
280	ONCOLOGY-GENERAL CLASSIFICATION
289	ONCOLOGY-OTHER ONCOLOGY
331	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-INJECTED
332	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-ORAL
335	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-IV

HCPCS Code	Description
Q0083	CHEMOTHERAPY ADMINISTRATION BY OTHER THAN INFUSION TECHNIQUE ONLY (E.G., SUBCUTANEOUS, INTRAMUSCULAR, PUSH), PER VISIT
Q0084	CHEMOTHERAPY ADMINISTRATION BY INFUSION TECHNIQUE ONLY, PER VISIT
Q0085	CHEMOTHERAPY ADMINISTRATION BY BOTH INFUSION TECHNIQUE AND OTHER TECHNIQUE(S) (E.G., SUBCUTANEOUS, INTRAMUSCULAR, PUSH), PER VISIT

46. RC Edits 3 Error.

Fatal. When revenue code(s) 28X, 331, 332, or 335 are present and HCPCS codes Q0083, Q0084, or Q0085 are present, and revenue code 636 is not present.

RC Code	Description
280	ONCOLOGY-GENERAL CLASSIFICATION
289	ONCOLOGY-OTHER ONCOLOGY
331	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-INJECTED
332	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-ORAL
335	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-IV
636	DRUGS - REQUIRING DETAILED CODING

HCPCS Code	Description
Q0083	CHEMOTHERAPY ADMINISTRATION BY OTHER THAN INFUSION TECHNIQUEONLY (E.G. SUBCUTANEOUS, INTRAMUSCULAR, PUSH), PER VISIT
Q0084	CHEMOTHERAPY ADMINISTRATION BY INFUSION TECHNIQUE ONLY, PER VISIT
Q0085	CHEMOTHERAPY ADMINISTRATION BY BOTH INFUSION
	TECHNIQUE AND OTHERTECHNIQUE(S) (E.G., SUBCUTANEOUS, INTRAMUSCULAR, PUSH), PER VISIT

47. RC Edits 4 Error.

Fatal. When revenue code(s) 28X, 331, 332, or 335 are present and HCPCS codes Q0083, Q0084, or Q0085 are present, revenue code 636 is present, and none of the following J codes is present:

RC Code	Description
280	ONCOLOGY-GENERAL CLASSIFICATION
289	ONCOLOGY-OTHER ONCOLOGY
331	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-INJECTED
332	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-ORAL
335	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-IV
636	DRUGS - REQUIRING DETAILED CODING

HCPCS Code	Description
Q0083	CHEMOTHERAPY ADMINISTRATION BY OTHER THAN INFUSION TECHNIQUE ONLY (E.G. SUBCUTANEOUS, INTRAMUSCULAR, PUSH), PER VISIT
Q0084	CHEMOTHERAPY ADMINISTRATION BY INFUSION TECHNIQUE ONLY, PER VISIT
Q0085	CHEMOTHERAPY ADMINISTRATION BY BOTH INFUSION TECHNIQUE AND OTHER TECHNIQUE(S) (E.G., SUBCUTANEOUS, INTRAMUSCULAR, PUSH), PER VISIT
J9000	DOXORUBICIN HCL, 10 MG VIAL
J9010	DOXORUBICIN HCL, 50 MG VIAL
J9020	ASPARAGINASE, UP TO 10,000 UNITS
J9040	BLEOMYCIN SULFATE, 15 UNIT AMPULE
J9045	INJECTION, CARBOPLATIN, PER 50 MG.
J9050	CARMUSTINE, BISCHLORETHYL NITROSOUREA, BCNU, 100 MG VIAL
J9060	CISPLATIN, 10 MG VIAL
J9062	CISPLATIN, 50 MG VIAL
J9070	CYCLOPHOSPHAMIDE, 10 CC OR 100 MG
J9080	CYCLOPHOSPHAMIDE, 20 CC OR 200 MG
J9090	CYCLOPHOSPHAMIDE, 30 CC OR 500 MG
J9091	CYCLOPHOSPHAMIDE, 1.0 GRAM
J9097	CYCLOPHOSPHAMIDE, LYOPHILIZED, 2.0 GRAM
J9100	CYTARABINE HCL, 100 MG
J9110	CYTARABINE HCL, 500 MG
J9120	DACTINOMYCIN, ACTINOMYCIN D, 3CC/0.5 MG
J9130	DACARBAZINE, 10 MG/ML (100 MG VIAL)
J9140	DACARBAZINE, 10 MG/ML (200 MG VIAL)
J9150	DAUNORUBICIN, HCL
J9165	INJECTION, DIETHYLSTILBESTROL DIPHOSPHATE, PER 250 MG
J9170	DROMOSTANOLONE, PROPIONATE, 5 MG/10 ML
J9181	ETOPOSIDE, UP TO 50 MG.
J9182	ETOPOSIDE, UP TO 100 MG.
J9190	FLUOROURACIL, 500 MGM AMP
J9200	FLOXURIDINE, 500 MG
J9208	INJECTION, IFOSFOMIDE, PER GM.
J9209	INJECTION, MESNA, PER 200 MG.
J9212	INTERFERON, 3 MILLION IU VIAL
J9218	LEUPROLIDE ACETATE, PER 1 MG
J9230	MECHLORETHAMINE HCL, (NITROGEN MUSTARD), HN2, 20 CC OR 10 MG
J9240	MEDROYPROGESTERONE ACETATE, 400 MG/ML
J9250	METHOTREXATE SODIUM MIX, 2 CC OR 5 MG
J9260	METHOTREXATE SODIUM MIX, 2 CC OR 50 MG
J9270	PLICAMYCIN (MITHRAMYCIN), 2500 MCG
J9280	MITOMYCIN, 5 MG
J9290	MITOMYCIN, 20 MG
J9291	MITOMYCIN, 40 MG
J9293	INJECTION, MITOXANTRONE HCL, PER 5 MG
J9295	POLYESTRADIOL PHOSPHATE 40 MG
J9300	QUINACRINE HCL, 10 CC/200 MGM

HCPCS Code	Description
J9320	STREPTOZOCIN
J9340	THIOTEPA, 15 MGM
J9360	VINBLASTINE SULFATE, 10 MG
J9370	VINCRISTINE SULFATE, 1 MG/1 ML (1 ML VIAL)
J9375	VINCRISTINE SULFATE 2 MG/2 ML (2 ML VIAL)
J9380	VINCRISTINE SULFATE, 5 MG/5 ML (5 ML VIAL)
J9999	NOT OTHERWISE CLASSIFIED, ANTINEOPLASTIC DRUGS

48. Edits 5 Error.

Fatal. If revenue code 42X is present then HCPCS code Q0086 must be present:

RC Code	Description
420	PHYSICAL THERAPY-GENERAL CLASSIFICATION
421	PHYSICAL THERAPY-VISIT CHARGE
422	PHYSICAL THERAPY-HOURLY CHARGE
423	PHYSICAL THERAPY-GROUP RATE
424	PHYSICAL THERAPY-EVALUATION OR RE-EVALUATION
429	PHYSICAL THERAPY-OTHER

HCPCS Code	Description
Q0086	PHYSICAL THERAPY EVALUATION/TREATMENT, PER VISIT

49. RC Edits 6 Error.

Fatal. If revenue code 43X is present then HCPCS code H5300 must be present:

.

RC Code	Description
430	OCCUPATIONAL THERAPY-GENERAL CLASSIFICATION
431	OCCUPATIONAL THERAPY-VISIT CHARGE
432	OCCUPATIONAL THERAPY-HOURLY CHARGE
433	OCCUPATIONAL THERAPY-GROUP RATE
434	OCCUPATIONAL THERAPY-EVALUATION OR RE-EVALUATION
439	OCCUPATIONAL THERAPY-OTHER (MAY INCLUDE RESTORATIVE THERAPY

HCPCS Code	Description
H5300	OCCUPATIONAL THERAPY

50. RC Edits 7 Error.

Fatal. If revenue code 44X is present then one or more HCPCS code in the range 92502-92599 must be present:

RC Code	Description
440	SPEECH-LANGUAGE PATHOLOGY-GENERAL CLASSIFICATION
441	SPEECH-LANGUAGE PATHOLOGY-VISIT CHARGE
442	SPEECH-LANGUAGE PATHOLOGY-HOURLY CHARGE
443	SPEECH-LANGUAGE PATHOLOGY-GROUP RATE
444	SPEECH-LANGUAGE PATHOLOGY-EVALUATION OR RE-EVALUATION
449	SPEECH-LANGUAGE PATHOLOGY-OTHER

HCPCS Code	Description
92502	EAR AND THROAT EXAMINATION
92504	EAR MICROSCOPY EXAMINATION
92506	SPEECH & HEARING EVALUATION
92507	SPEECH/HEARING THERAPY
92508	SPEECH/HEARING THERAPY
92511	NASOPHARYNGOSCOPY
92512	NASAL FUNCTION STUDIES
92516	FACIAL NERVE FUNCTION TEST
92520	LARYNGEAL FUNCTION STUDIES
92531	SPONTANEOUS NYSTAGMUS STUDY
92532	POSITIONAL NYSTAGMUS STUDY
92533	CALORIC VESTIBULAR TEST
92534	OPTOKINETIC NYSTAGMUS
92541	SPONTANEOUS NYSTAGMUS TEST
92542	POSITIONAL NYSTAGMUS TEST
92543	CALORIC VESTIBULAR TEST
92544	OPTOKINETIC NYSTAGMUS TEST
92545	OSCILLATING TRACKING TEST
92546	TORSION SWING RECORDING
92547	SUPPLEMENTAL ELECTRICAL TEST
92551	PURE TONE HEARING TEST, AIR
92552	PURE TONE AUDIOMETRY, AIR
92553	AUDIOMETRY, AIR & BONE
92555	SPEECH THRESHOLD AUDIOMETRY
92556	SPEECH AUDIOMETRY, COMPLETE
92557	COMPREHENSIVE HEARING TEST
92559	GROUP AUDIOMETRIC TESTING
92560	BEKESY AUDIOMETRY, SCREEN
92561	BEKESY AUDIOMETRY, DIAGNOSIS
92562	LOUDNESS BALANCE TEST
92563	TONE DECAY HEARING TEST
92564	SISI HEARING TEST
92565	STENGER TEST, PURE TONE
92567	TYMPANOMETRY

HCPCS Code	Description
92568	ACOUSTIC REFLEX TESTING
92569	ACOUSTIC REFLEX DECAY TEST
92571	FILTERED SPEECH HEARING TEST
92572	STAGGERED SPONDAIC WORD TEST
92573	LOMBARD TEST
92574	SWINGING STORY TEST
92575	SENSORINEURAL ACUITY TEST
92576	SYNTHETIC SENTENCE TEST
92577	STENGER TEST, SPEECH
92578	DELAYED AUDITORY FEEDBACK
92580	ELECTRODERMAL AUDIOMETRY
92582	CONDITIONING PLAY AUDIOMETRY
92583	SELECT PICTURE AUDIOMETRY
92584	ELECTROCOCHLEOGRAPHY
92585	BRAINSTEM EVOKED AUDIOMETRY
92589	AUDITORY FUNCTION TEST(S)
92590	HEARING AID EXAM, ONE EAR
92591	HEARING AID EXAM, BOTH EARS
92592	HEARING AID CHECK, ONE EAR
92593	HEARING AID CHECK, BOTH EARS
92594	ELECTRO HEARING AID TEST,ONE
92595	ELECTRO HEARING AID TEST,BOTH
92596	EAR PROTECTOR EVALUATION
92599	ENT PROCEDURE/SERVICE

51. RC Edits 8 Error.

Fatal. If revenue code 924 is present then one or more of the following HCPCS codes 90000, 95000-95082, or 95115-95199 must be present:

RC Code	Description
924	OTHER DIAGNOSTIC SERVICES-ALLERGY TEST

HCPCS Code	Description
90000	OFFICE/OP VISIT, NEW, BRIEF
95000	ALLERGY SKIN TESTS, 1-30
95001	ALLERGY SKIN TESTS, 31-60
95002	ALLERGY SKIN TESTS, 61-90
95003	ALLERGY SKIN TESTS, OVER 90
95005	SENSITIVITY SKIN TESTS, 1-5
95006	SENSITIVITY SKIN TESTS, 6-10
95007	SENSITIVITY SKIN TESTS,11-15
95011	SENSITIVITY SKIN TESTS, 15+
95014	SENSITIVITY SKIN TESTS, 1-5

HCPCS Code	Description
95016	SENSITIVITY SKIN TESTS, 6-10
95017	SENSITIVITY SKIN TESTS,11-15
95018	SENSITIVITY SKIN TESTS, 15+
95020	ALLERGY SKIN TESTS, 1-10
95021	ALLERGY SKIN TESTS, 11-20
95022	ALLERGY SKIN TESTS, 21-30
95023	ALLERGY SKIN TESTS, OVER 30
95027	SKIN END POINT TITRATION
95030	ALLERGY SKIN TESTS, 2
95031	ALLERGY SKIN TESTS, 3-4
95032	ALLERGY SKIN TESTS, 5-6
95033	ALLERGY SKIN TESTS, 7-8
95034	ALLERGY SKIN TESTS, OVER 8
95040	ALLERGY PATCH TESTS, 1-10
95041	ALLERGY PATCH TESTS, 11-20
95042	ALLERGY PATCH TESTS, 21-30
95043	ALLERGY PATCH TESTS, OVER 30
95050	PHOTO PATCH TESTS, 1-10
95051	PHOTO PATCH TESTS, OVER 10
95056	PHOTOSENSITIVITY TESTS
95060	EYE ALLERGY TESTS
95065	NOSE ALLERGY TEST
95070	BRONCHIAL ALLERGY TESTS
95071	BRONCHIAL ALLERGY TESTS
95075	INGESTION CHALLENGE TEST
95078	PROVOCATIVE TESTING
95080	PASSIVE TRANSFER TESTS, 1-10
95081	PASSIVE TRANSFER TESTS,11-20
95082	PASSIVE TRANSFER TESTS, 20+
95115	IMMUNOTHERAPY, ONE INJECTION
95117	IMMUNOTHERAPY INJECTIONS
95120	IMMUNOTHERAPY, ONE ANTIGEN
95125	IMMUNOTHERAPY, MANY ANTIGENS
95130	IMMUNOTHERAPY, INSECT VENOM
95131	IMMUNOTHERAPY, INSECT VENOMS
95132	IMMUNOTHERAPY, INSECT VENOMS
95133	IMMUNOTHERAPY, INSECT VENOMS
95134	IMMUNOTHERAPY, INSECT VENOMS
95135	IMMUNOTHERAPY, ONE ANTIGEN
95140	IMMUNOTHERAPY, MANY ANTIGENS
95145	ANTIGEN THERAPY SERVICES
95146	ANTIGEN THERAPY SERVICES
95147	ANTIGEN THERAPY SERVICES
95148	ANTIGEN THERAPY SERVICES
95149	ANTIGEN THERAPY SERVICES
95150	ANTIGEN THERAPY SERVICES
95155	ANTIGEN THERAPY SERVICES

HCPCS Code	Description
95170	ANTIGEN THERAPY SERVICES
95180	RAPID DESENSITIZATION
95199	ALLERGY IMMUNOLOGY SERVICES

52. *RC Edits 9 Error.*

Fatal. If revenue code 917 is present then one or more HCPCS code 90900-90915 must be present:

RC Code	Description
917	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - BIOFEEDBACK

HCPCS Code	Description
90900	BIOFEEDBACK, ELECTROMYOGRAM
90902	BIOFEEDBACK, NERVE IMPULSE
90904	BIOFEEDBACK, BLOOD PRESSURE
90906	BIOFEEDBACK, BLOOD FLOW
90908	BIOFEEDBACK, BRAIN WAVES
90910	BIOFEEDBACK, OCULOGRAM
90915	BIOFEEDBACK, UNSPECIFIED

53. *RC Edits 10 Error.*

Fatal. If revenue code 900, 910, 911, 912, 913, 914, 915, 916, 918, or 919 is present then one or more HCPCS code 90801, 90825-90862, 90880-90899) must be present:

RC Code	Description
900	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-GENERAL CLASSIFICATION
910	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-GENERAL CLASSIFICATION
911	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-REHABILITATION
912	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-DAY CARE
913	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-NIGHT CARE
914	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-INDIVIDUAL THERAPY
915	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-GROUP THERAPY
916	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-FAMILY THERAPY
918	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-TESTING
919	PSYCHIATRIC/PSYCHOLOGICAL SERVICES-OTHER

HCPCS Code	Description
90801	PSYCHIATRIC INTERVIEW
90825	EVALUATION OF TESTS/RECORDS
90830	PSYCHOLOGICAL TESTING

HCPCS Code	Description
90835	SPECIAL INTERVIEW
90841	PSYCHOTHERAPY
90843	PSYCHOTHERAPY, 20-30 MIN
90844	PSYCHOTHERAPY, 45-50 MIN
90845	MEDICAL PSYCHOANALYSIS
90846	SPECIAL FAMILY THERAPY
90847	SPECIAL FAMILY THERAPY
90849	SPECIAL FAMILY THERAPY
90853	SPECIAL GROUP THERAPY
90855	INDIVIDUAL PSYCHOTHERAPY
90857	SPECIAL GROUP THERAPY
90862	MEDICATION MANAGEMENT
90880	MEDICAL HYPNOTHERAPY
90882	ENVIRONMENTAL MANIPULATION
90887	CONSULTATION WITH FAMILY
90889	PREPARATION OF REPORT
90899	PSYCHIATRIC SERVICE/THERAPY

54. RC Edits 11 Error.

Fatal. If revenue code 902 or 903 is present then one or more HCPCS code Q0082 must be present:

RC Code	Description
902	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-MILIEU THERAPY
903	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-PLAY THERAPY

HCPCS Code	Description
Q0082	ACTIVITY THERAPY FURNISHED IN CONNECTION WITH PARTIAL HOSPITALIZATION (E.G., MUSIC, DANCE, ART OR PLAY THERAPIES THAT ARE NOT PRIMARILY RECREATIONAL), PER VISIT

55. RC Edits 12 Error.

Fatal. If revenue code 901 is present then one or more HCPCS code 90870 or 90871 must be present:

RC Code	RC Description
901	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-ELECTROSHOCK TREATMENT

HCPCS Code	Description
90870	ELECTROCONVULSIVE THERAPY
90871	ELECTROCONVULSIVE THERAPY

56. *RC Edits 13 Error.*

Fatal. If revenue code 260 or 269 is present then one or more HCPCS code Q0081 must be present:

RC Code	Description
260	IV THERAPY-GENERAL CLASSIFICATION
269	IV THERAPY-OTHER IV THERAPY

HCPCS Code	Description
Q0081	INFUSION THERAPY, USING OTHER THAN CHEMOTHERAPEUTIC DRUGS, PER VISIT

57. *RC Edits 14 Error.*

Fatal. If revenue code 48X is present then one or more HCPCS code 92950-93960 must be present:

RC Code	Description
480	CARDIOLOGY-GENERAL CLASSIFICATION
481	CARDIOLOGY-CARDIAC CATH LAB
482	CARDIOLOGY-STRESS TEST
489	CARDIOLOGY-OTHER

HCPCS Code	Description
92950	HEART/LUNG/RESUSCITATION/CPR
92953	TEMPORARY EXTERNAL PACING
92960	HEART ELECTROCONVERSION
92970	CARDIOASSIST, INTERNAL
92971	CARDIOASSIST, EXTERNAL
92975	DISSOLVE CLOT, HEART VESSEL
92977	DISSOLVE CLOT, HEART VESSEL
92982	CORONARY ARTERY DILATION
92984	CORONARY ARTERY DILATION
92986	REVISION OF AORTIC VALVE
92990	REVISION OF PULMONARY VALVE
93005	ELECTROCARDIOGRAM, TRACING
93012	TRANSMISSION OF ECG

HCPCS Code	Description
93017	CARDIOVASCULAR STRESS TEST
93024	CARDIAC DRUG STRESS TEST
93041	RHYTHM ECG, TRACING
93202	PHONOCARDIOGRAM & ECG LEAD
93208	SPECIAL PHONOCARDIOGRAM
93210	INTRACARDIAC PHONOCARDIOGRAM
93221	VECTORCARDIOGRAM TRACING
93225	ECG MONITOR/RECORD, 24 HRS
93226	ECG MONITOR/REPORT, 24 HRS
93231	ECG MONITOR/RECORD, 24 HRS
93232	ECG MONITOR/REPORT, 24 HRS
93236	ECG MONITOR/REPORT, 24 HRS
93255	APEXCARDIOGRAPHY
93268	ECG RECORD/REVIEW
93278	ECG/SIGNAL-AVERAGED
93280	CARDIAC FLUOROSCOPY
93307	ECHO EXAM OF HEART
93308	ECHO EXAM OF HEART
93312	ECHO EXAM OF HEART
93320	DOPPLER ECHO EXAM, HEART
93321	DOPPLER ECHO EXAM, HEART
93325	DOPPLER COLOR FLOW
93350	ECHO EXAM OF HEART
93501	RIGHT HEART CATHETERIZATION
93503	INSERT/PLACE HEART CATHETER
93505	BIOPSY OF HEART LINING
93510	LEFT HEART CATHETERIZATION
93511	LEFT HEART CATHETERIZATION
93514	LEFT HEART CATHETERIZATION
93524	LEFT HEART CATHETERIZATION
93526	RT & LT HEART CATHETERS
93527	RT & LT HEART CATHETERS
93528	RT & LT HEART CATHETERS
93529	RT, LT HEART CATHETERIZATION
93536	INSERT CIRCULATION ASSIST
93541	INJECTION FOR LUNG ANGIOGRAM
93542	INJECTION FOR HEART X-RAYS
93543	INJECTION FOR HEART X-RAYS
93544	INJECTION FOR AORTOGRAPHY
93545	INJECTION FOR CORONARY X-RAYS
93546	HEART CATHETER & ANGIOGRAM
93547	HEART CATHETER & ANGIOGRAM
93548	HEART CATHETER & ANGIOGRAM
93549	HEART CATHETER & ANGIOGRAM
93550	HEART CATHETER & ANGIOGRAM
93551	X-RAY AORTOCORONARY BYPASS
93552	HEART CATHETER & ANGIOGRAM

HCPCS Code	Description
93553	HEART CATHETER & ANGIOGRAM
93561	CARDIAC OUTPUT MEASUREMENT
93562	CARDIAC OUTPUT MEASUREMENT
93600	BUNDLE OF HIS RECORDING
93602	INTRA-ATRIAL RECORDING
93603	RIGHT VENTRICULAR RECORDING
93607	RIGHT VENTRICULAR RECORDING
93609	MAPPING OF TACHYCARDIA
93610	INTRA-ATRIAL PACING
93612	INTRAVENTRICULAR PACING
93615	ESOPHAGEAL RECORDING
93616	ESOPHAGEAL RECORDING
93618	HEART RHYTHM PACING
93620	ELECTROPHYSIOLOGY EVALUATION
93621	ELECTROPHYSIOLOGY EVALUATION
93622	ELECTROPHYSIOLOGY EVALUATION
93623	STIMULATION, PACING HEART
93624	ELECTROPHYSIOLOGIC STUDY
93631	HEART PACING, MAPPING
93640	EVALUATION HEART DEVICE
93650	ABLATE HEART DYSRHYTHM FOCUS
93660	TILT TABLE EVALUATION
93720	TOTAL BODY PLETHYSMOGRAPHY
93721	PLETHYSMOGRAPHY TRACING
93722	PLETHYSMOGRAPHY REPORT
93731	ANALYZE PACEMAKER SYSTEM
93732	ANALYZE PACEMAKER SYSTEM
93733	TELEPHONE ANALYSIS, PACEMAKER
93734	ANALYZE PACEMAKER SYSTEM
93735	ANALYZE PACEMAKER SYSTEM
93736	TELEPHONE ANALYSIS, PACEMAKER
93737	ANALYZE CARDIO/DEFIBRILLATOR
93738	ANALYZE CARDIO/DEFIBRILLATOR
93740	TEMPERATURE GRADIENT STUDIES
93760	CEPHALIC THERMOGRAM
93762	PERIPHERAL THERMOGRAM
93770	MEASURE VENOUS PRESSURE
93784	AMBULATORY BP MONITORING
93786	AMBULATORY BP RECORDING
93788	AMBULATORY BP ANALYSIS
93790	REVIEW/REPORT BP RECORDING
93797	CARDIAC REHAB
93798	CARDIAC REHAB/MONITOR
93799	CARDIOVASCULAR PROCEDURE
93850	CEREBRAL ARTERY STUDY
93860	CAROTID ARTERY STUDY
93870	CAROTID ARTERY IMAGING

HCPCS Code	Description
93875	EXTRACRANIAL STUDY
93880	EXTRACRANIAL STUDY
93882	EXTRACRANIAL STUDY
93886	INTRACRANIAL STUDY
93888	INTRACRANIAL STUDY
93890	UPPER LIMB ARTERY STUDY
93910	LOWER LIMB ARTERY STUDY
93920	UPPER EXTREMITY STUDY
93921	LOWER EXTREMITY STUDY
93925	LOWER EXTREMITY STUDY
93926	LOWER EXTREMITY STUDY
93930	UPPER EXTREMITY STUDY
93931	UPPER EXTREMITY STUDY
93950	LIMB VEIN STUDY
93960	VENOUS FLOW STUDY, CALF

58. *RC Edits 15 Error.*

Fatal. If revenue code 41X or 46X is present then one or more HCPCS code of the range 94010-94799 must be present:

RC Code	Description
410	RESPIRATORY SERVICES-GENERAL CLASSIFICATION
412	RESPIRATORY SERVICES-INHALATION SERVICES
413	RESPIRATORY SERVICES-HYPERBARIC OXYGEN THERAPY
419	RESPIRATORY SERVICES-OTHER
460	PULMONARY FUNCTION-GENERAL CLASSIFICATION
469	PULMONARY FUNCTION-OTHER

HCPCS Code	Description
94010	BREATHING CAPACITY TEST
94060	EVALUATION OF WHEEZING
94070	EVALUATION OF WHEEZING
94150	VITAL CAPACITY TEST
94160	VITAL CAPACITY SCREENING
94200	LUNG FUNCTION TEST (MBC/MVV)
94240	RESIDUAL LUNG CAPACITY
94250	EXPIRED GAS COLLECTION
94260	THORACIC GAS VOLUME
94350	LUNG NITROGEN WASHOUT CURVE
94360	MEASURE AIRFLOW RESISTANCE
94370	BREATH AIRWAY CLOSING VOLUME
94375	RESPIRATORY FLOW VOLUME LOOP
94400	CO2 BREATHING RESPONSE CURVE
94450	HYPOXIA RESPONSE CURVE

HCPCS Code	Description
94620	PULMONARY STRESS TESTING
94640	AIRWAY INHALATION TREATMENT
94642	AEROSOL INHALATION TREATMENT
94650	PRESSURE BREATHING (IPPB)
94651	PRESSURE BREATHING (IPPB)
94652	PRESSURE BREATHING (IPPB)
94656	INITIAL,VENTILATORMANAGEMENT
94657	CONT. VENTILATOR MANAGEMENT
94660	POS AIRWAY PRESSURE, CPAP
94662	NEG PRESSURE VENTILATION,CNP
94664	AEROSOL OR VAPOR INHALATIONS
94665	AEROSOL OR VAPOR INHALATIONS
94667	CHEST WALL MANIPULATION
94668	CHEST WALL MANIPULATION
94680	EXHALED AIR ANALYSIS: O2
94681	EXHALED AIR ANALYSIS: O2,CO2
94690	EXHALED AIR ANALYSIS
94700	BLOOD GAS ANALYSIS
94705	ARTERIAL BLOOD GAS ANALYSES
94710	ARTERIAL BLOOD GAS ANALYSES
94715	HEMOGLOBIN-OXYGEN AFFINITY
94720	MONOXIDE DIFFUSING CAPACITY
94725	MEMBRANE DIFFUSION CAPACITY
94750	PULMONARY COMPLIANCE STUDY
94760	MEASURE BLOOD OXYGEN LEVEL
94761	MEASURE BLOOD OXYGEN LEVEL
94762	MEASURE BLOOD OXYGEN LEVEL
94770	EXHALED CARBON DIOXIDE TEST
94772	BREATH RECORDING, INFANT
94799	PULMONARY SERVICE/PROCEDURE

59. *No Cost / Charge Ratio For Provider.*

    Fatal. Based on HCFA data, providers with questionable cost / charge ratios are excluded.

60. *Take Home Drugs Without Occurrence Code 36.*

    Non-fatal. Take Home Drug Charges Excluded.

61. *Occurrence Code 36 without Take Home Drugs.*

    Non-fatal. No action taken.

62. *Take Home Drugs with Occurrence Code 36.*

    Non-fatal. Take Home Drug Charges Allowed.

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APPENDIX F

Revenue Center Allocation

The Revenue Center Allocation (RCA) specifies the action associated with each revenue center. In the RCA, there are six different types of actions that can be taken depending on the value of the revenue center code.

Error

The occurrence of this revenue center will be interpreted as an error and the claim will be excluded from the analysis (e.g., revenue center 201 ICU surgical). The revenue centers that are considered errors are primarily revenue centers associated with inpatient care or other settings such as home health services. In addition, if there is no revenue center code or an invalid revenue center code, the claim will also be excluded from the analysis.

Exclude

The charge associated with this revenue center will be excluded from the analysis (e.g., revenue center 998, beauty shop/barber). Only the revenue trailer containing this revenue center will be excluded and the rest of the claim will be used in the analysis.

Allocate

The charge associated with this revenue center will be included in the primary significant procedure APG or the medical APG (e.g., revenue center 251, generic drugs).

Require CPT

When this revenue center occurs without a valid CPT-4 in the revenue trailer, the claim is considered in error and is deleted from the analysis (e.g., revenue center 301, Laboratory-Chemistry)

Allocate SP only

The charge associated with this revenue center will be included only in the primary significant procedure APG. If this revenue center occurs with a medical APG the claim will be considered an error and excluded from the analysis (e.g., revenue center 360, operating room services)

Require CPT, Assign APG

If no CPT-4 code occurs with this revenue center (i.e., no APG) then an APG will be assigned to the revenue trailer based solely on the revenue center (e.g., revenue center 820, Hemodialysis).

Require CPT, Assign APG, Error if Not SP

If no CPT-4 code occurs with this revenue center (i.e., no APG) then an APG will be assigned to the revenue trailer based solely on the revenue center (e.g., revenue center 370, Anesthesia). The use of the revenue center to assign an APG is necessary since hospitals were not required to report certain CPT-4 codes. If the claim is not a significant procedure then the claim is considered an error.

The RCA basically performs two functions. It edits the data to remove inconsistent data from the analysis and it determines the revenue center charges that should be allocated to the primary significant procedure or the medical APG.

The first column in the Revenue Center Allocation (RCA) lists each revenue center code and the second column lists the action that is to be taken.

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
001	Ignore (Total Charge)	TOTAL CHARGE
100	Error	ALL INCLUSIVE RATE-ROOM AND BOARD PLUS ANCILARY
101	Error	ALL INCLUSIVE RATE-ROOM AND BOARD
110	Error	PRIVATE MEDICAL OR GENERAL-GENERAL CLASSIFICATION
111	Error	PRIVATE MEDICAL OR GENERAL-MEDICAL/ SURGICAL/GYN
112	Error	PRIVATE MEDICAL OR GENERAL-OB
113	Error	PRIVATE MEDICAL OR GENERAL-PEDIATRIC
114	Error	PRIVATE MEDICAL OR GENERAL-PSYCHIATRIC
115	Error	PRIVATE MEDICAL OR GENERAL-HOSPICE
116	Error	PRIVATE MEDICAL OR GENERAL- DETOXIFICATION
117	Error	PRIVATE MEDICAL OR GENERAL-ONCOLOGY
118	Error	PRIVATE MEDICAL OR GENERAL-REHABILI- TATION
119	Error	PRIVATE MEDICAL OR GENERAL-OTHER
120	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL) - GENERAL CLASSIFICATION
121	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL) - MEDICAL/SURGICAL/GYN
122	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL) - OB
123	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL) - PEDIATRIC
124	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL)- PSYCHIATRIC
125	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL) - HOSPICE
126	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL) - DETOXIFICATION
127	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL) - ONCOLOGY
128	Error	SEMI-PROVATE TWO BED (MEDICAL OR GENERAL) - REHABILITATION
129	Error	SEMI-PRIVATE TWO BED (MEDICAL OR GENERAL) - OTHER
130	Error	SEMI-PRIVATE THREE AND FOUR BEDS - GENERAL CLASSIFICATION
131	Error	SEMI-PRIVATE THREE AND FOUR BEDS - MEDICAL/SURGICAL/GYN
132	Error	SEMI-PRIVATE THREE AND FOUR BEDS - OB
133	Error	SEMI-PRIVATE THREE AND FOUR BEDS - PEDIATRIC
134	Error	SEMI-PRIVATE THREE AND FOUR BEDS - PSYCHIATRIC
135	Error	SEMI-PRIVATE THREE AND FOUR BEDS - HOSPICE
136	Error	SEMI-PRIVATE THREE AND FOUR BEDS - DETOXIFICATION
137	Error	SEMI-PRIVATE THREE AND FOUR BEDS - ONCOLOGY
138	Error	SEMI_PRIVATE THREE AND FOUR BEDS - REHABILITATION
139	Error	SEMI-PRIVATE THREE AND FOUR BEDS -OTHER
140	Error	PRIVATE (DELUXE)-GENERAL CLASSIFICATION
141	Error	PRIVATE (DELUXE)-MEDICAL/SURGICAL/GYN
142	Error	PRIVATE (DELUXE) - OB
143	Error	PRIVATE (DELUXE) - PEDIATRIC
144	Error	PRIVATE (DELUXE) - PSYCHIATRIC
145	Error	PRIVATE (DELUXE) - HOSPICE
146	Error	PRIVATE (DELUXE) - DETOXIFICATION
147	Error	PRIVATE (DELUXE) - ONCOLOGY
148	Error	PRIVATE (DELUXE) - REHABILIATION

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
149	Error	PRIVATE (DELUXE) - OTHER
150	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - GENERAL CLASSIFICATION
151	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - MEDICAL/SURGICAL/GYN
152	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - OB
153	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - PEDIATRIC
154	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - PSYCHIATRIC
155	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - HOSPICE
156	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - DETOXIFICATION
157	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - ONCOLOGY
158	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - REHABILITATION
159	Error	ROOM AND BOARD WARD (MEDICAL OR GENERAL) - OTHER
160	Error	OTHER ROOM AND BOARD-GENERAL CLASSIFICATION
164	Error	OTHER ROOM AND BOARD-STERILE ENVIRONMENT
167	Error	OTHER ROOM AND BOARD-SELF CARE
169	Error	OTHER ROOM AND BOARD-OTHER
170	Error	NURSERY-GENERAL CLASSIFICATION
171	Error	NURSERY-NEWBORN
172	Error	NURSERY-PREMATURE
175	Error	NURSERY-NEONATAL ICU
179	Error	NURSERY-OTHER
180	Error	LEAVE OF ABSENCE-GENERAL CLASSIFICATION
182	Error	LEAVE OF ABSENCE-PATIENT CONVENIENCE- CHARGES BILLABLE
183	Error	LEAVE OF ABSENCE-THERAPEUTIC LEAVE
184	Error	LEAVE OF ABSENCE-ICF MENTALLY RETARDED- ANY REASON
185	Error	LEAVE OF ABSENCE-NURSING HOME (HOSPITALIZATION)
189	Error	LEAVE OF ABSENCE-OTHER LEAVE OF ABSENCE
200	Error	INTENSIVE CARE-GENERAL CLASSIFICATION
201	Error	INTENSIVE CARE-SURGICAL
202	Error	INTENSIVE CARE-MEDICAL
203	Error	INTENSIVE CARE-PEDIATRIC
204	Error	INTENSIVE CARE-PSYCHIATRIC
206	Error	INTENSIVE CARE-POST ICU
207	Error	INTENSIVE CARE-BURN CARE
208	Error	INTENSIVE CARE-TRAUMA
209	Error	INTENSIVE CARE-OTHER INTENSIVE CARE
210	Error	CORONARY CARE-GENERAL CLASSIFICATION
211	Error	CORONARY CARE-MYOCARDIAL INFRACTION
212	Error	CORONARY CARE-PULMONARY CARE
213	Error	CORONARY CARE-HEART TRANSPLANT
214	Error	CORONARY CARE-POST CCU
219	Error	CORONARY CARE-OTHER CORONARY CARE
220	Error	SPECIAL CHARGES-GENERAL CLASSIFICATION
221	Error	SPECIAL CHARGES-ADMISSION CHARGE
222	Error	SPECIAL CHARGES-TECHNICAL SUPPORT CHARGE
223	Error	SPECIAL CHARGES-U.R. SERVICE CHARGE
224	Error	SPECIAL CHARGES-LATE DISCHARGE, MEDICALLY NECESSARY
229	Error	SPECIAL CHARGES-OTHER SPECIAL CHARGES

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
230	Error	INCREMENTAL NURSING CHARGE RATE- GENERAL CLASSIFICATION
231	Error	INCREMENTAL NURSING CHARGE RATE-NURSERY
232	Error	INCREMENTAL NURSING CHARGE RATE-OB
233	Error	INCREMENTAL NURSING CHARGE RATE-ICU (INCLUDES TRANSITIONAL CARE)
234	Error	INCREMENTAL NURSING CHARGE RATE-CCU (INCLUDES TRANSITIONAL CARE)
235	Error	INCREMENTAL NURSING CHARGE RATE-HOSPICE
239	Error	INCREMENTAL NURSING CHARGE RATE-OTHER
240	Error	ALL INCLUSIVE ANCILLARY-GENERAL CLASSIFICATION
249	Error	ALL INCLUSIVE ANCILLARY-OTHER INCLUSIVE ANCILLARY
250	Allocate	PHARMACY-GENERAL CLASSIFICATION
251	Allocate	PHARMACY-GENERIC DRUGS
252	Allocate	PHARMACY-NONGENERIC DRUGS
253	Allocate	PHARMACY-TAKE HOME DRUGS
254	Allocate	PHARMACY-DRUGS INCIDENT TO OTHER DIAGNOSTIC SERVICES
255	Allocate	PHARMACY-DRUGS INCIDENT TO RADIOLOGY
256	Allocate	PHARMACY-EXPERIMENTAL DRUGS
257	Allocate	PHARMACY-NON-PRESCRIPTION
258	Allocate	PHARMACY-IV SOLUTIONS
259	Allocate	PHARMACY-OTHER PHARMACY
260	Require CPT, Assign APG 372	IV THERAPY-GENERAL CLASSIFICATION
261	Require CPT, Assign APG 372	IV THERAPY-INFUSION PUMP
262	Exclude	IV THERAPY-PHARMACY SVCS
263	Exclude	IV THERAPY-DRUG/SUPPLY DELIVERY
264	Exclude	IV THERAPY-SUPPLIES
269	Require CPT, Assign APG 372	IV THERAPY-OTHER IV THERAPY
270	Allocate	MEDICAL/SURGICAL SUPPLIES-GENERAL CLASSIFICATION
271	Allocate	MEDICAL/SURGICAL SUPPLIES-NONSTERILE SUPPLY
272	Allocate	MEDICAL/SURGICAL SUPPLIES-STERILE SUPPLY
273	Allocate	MEDICAL/SURGICAL SUPPLIES-TAKE HOME SUPPLIES
274	Allocate	MEDICAL/SURGICAL SUPPLIES-PROSTHETIC/ ORTHOTIC DEVICES
275	Allocate	MEDICAL/SURGICAL SUPPLIES-PACE MAKER
276	Allocate	MEDICAL/SURGICAL SUPPLIES-INTRAOCULAR LENS
277	Allocate	MEDICAL/SURGICAL SUPPLIES-OXYGEN-TAKE HOME
278	Allocate	MEDICAL/SURGICAL SUPPLIES-OTHER IMPLANTS
279	Allocate	MEDICAL/SURGICAL SUPPLIES-OTHER DEVICES
280	Allocate	ONCOLOGY-GENERAL CLASSIFICATION
289	Allocate	ONCOLOGY-OTHER ONCOLOGY
290	Error	DURABLE MEDICAL EQUIPMENT(DME) - (OTHER THAN RENAL)-GENERAL CLASSIFICATION
291	Error	DME (OTHER THAN RENAL) - RENTAL
292	Error	DME (OTHER THAN RENAL) - PURCHASE OF NEW DME
293	Error	DME (OTHER THAN RENAL) - PURCHASE OF USED DME
294	Exclude	DME (OTHER THAN RENAL) - SUPPLIES/DRUGS FOR DME EFFECTIVENESS (HHA ONLY)

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
299	Error	DME (OTHER THAN RENAL) - OTHER
300	RequireCPT-4	LABORATORY-GENERAL CLASSIFICATION
301	RequireCPT-4	LABORATORY-CHEMISTRY
302	RequireCPT-4	LABORATORY-IMMUNOLOGY
303	RequireCPT-4	LABORATORY-RENAL PATIENT (HOME)
304	RequireCPT-4	LABORATORY-NON-ROUTINE DIALYSIS
305	RequireCPT-4	LABORATORY-HEMATOLOGY
306	RequireCPT-4	LABORATORY-BACTERIOLOGY & MICROBIOLOGY
307	RequireCPT-4	LABORATORY-UROLOGY
309	RequireCPT-4	LABORATORY-OTHER LABORATORY
310	Require CPT, Assign APG 332, Error If Not SP	LABORATORY PATHOLOGICAL-GENERAL CLASSIFICATION
311	Require CPT, Assign APG 332, Error If Not SP	LABORATORY PATHOLOGICAL-CYTOLOGY
312	Require CPT, Assign APG 332, Error If Not SP	LABORATORY PATHOLOGICAL-HISTOLOGY
314	Require CPT, Assign APG 332, Error If Not SP	LABORATORY PATHOLOGICAL-BIOPSY
319	Require CPT, Assign APG 332, Error If Not SP	LABORATORY PATHOLOGICAL-OTHER
320	RequireCPT-4	RADIOLOGY-DIAGNOSIC-GENERAL CLASSIFICATION
321	Require CPT, Assign APG 076	RADIOLOGY-DIAGNOSTIC-ANGIOCARDIOGRAPHY
322	None	RADIOLOGY-DIAGNOSTIC-ARTHROGRAPHY
323	Require CPT, Assign APG 255	RADIOLOGY-DIAGNOSTIC-ARTERIOGRAPHY
324	Require CPT, Assign APG 310	RADIOLOGY-DIAGNOSTIC-CHEST X-RAY
329	RequireCPT-4	RADIOLOGY-DIAGNOSTIC-OTHER
330	RequireCPT-4	RADIOLOGY-THERAPEUTIC-GENERAL CLASSIFICATION
331	RequireCPT-4	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY- INJECTED
332	RequireCPT-4	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY- ORAL
333	Require CPT, Assign APG 252	RADIOLOGY-THERAPEUTIC-RADIATION THERAPY
335	RequireCPT-4	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-IV
339	RequireCPT-4	RADIOLOTY-THERAPEUTIC-OTHER
340	RequireCPT-4	NUCLEAR MEDICINE-GENERAL CLASSIFICATION
341	RequireCPT-4	NUCLEAR MEDICINE-DIAGNOSTIC
342	RequireCPT-4	NUCLEAR MEDICINE-THERAPEUTIC
349	RequireCPT-4	NUCLEAR MEDICINE-OTHER
350	Require CPT, Assign APG 307	COMPUTED TOMOGRAPHIC (CT) SCAN-GENERAL CLASSIFICATION
351	Require CPT, Assign APG 307	CT SCAN-HEAD SCAN

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
352	Require CPT, Assign APG 307	CT SCAN-BODY SCAN
359	Require CPT, Assign APG 307	CT SCAN-OTHER CT SCANS
360	Allocate SP Only	OPERATING ROOM SERVICES-GENERAL CLASSIFICATION
361	Allocate SP Only	OPERATING ROOM SERVICES-MINOR SURGERY
362	Allocate SP Only	OPERATING ROOM SERVICES-ORGAN TRANSPLANT-OTHER THAN KIDNEY
367	Allocate SP Only	OPERATING ROOM SERVICES-KIDNEY TRANSPLANT
369	Allocate SP Only	OPERATING ROOM SERVICES-OTHER OPERATING ROOM SERVICES
370	Require CPT, Assign APG 321, Error If Not SP	ANESTHESIA-GENERAL CLASSIFICATION
371	Require CPT, Assign APG 321, Error If Not SP	ANESTHESIA-INCIDENT TO RAD
372	Require CPT, Assign APG 321, Error If Not SP	ANESTHESIA-INCIDENT TO OTHER DIAGNOSTIC SERVICES
374	Exclude	ANESTHESIA-ACUPUNCTURE
379	Require CPT, Assign APG 321, Error If Not SP	ANESTHESIA-OTHER ANESTHESIA
380	Allocate	BLOOD-GENERAL CLASSIFICATION
381	Allocate	BLOOD-PACKED RED CELLS
382	Allocate	BLOOD-WHOLE BLOOD
383	Allocate	BLOOD-PLASMA
384	Allocate	BLOOD-PLATELETS
385	Allocate	BLOOD-LEUCOCYTES
386	Allocate	BLOOD-OTHER COMPONENTS
387	Allocate	BLOOD-OTHER DERIVATIVES (CRYOPRICIPATATES)
389	Allocate	BLOOD-OTHER BLOOD
390	Allocate	BLOOD STORAGE AND PROCESSING-GENERAL CLASSIFICATION
391	Allocate	BLOOD STORAGE AND PROCESSING-BLOOD ADMINISTRATION
399	Allocate	BLOOD STORAGE AND PROCESSING-OTHER BLOOD STORAGE AND PROCESSING
400	Require CPT-4	OTHER IMAGING SERVICES-GENERAL CLASSIFICATION
401	Require CPT, Assign APG 308	OTHER IMAGING SERVICES-DIAGNOSTIC MAMMOGRAPHY
402	Require CPT, Assign APG 305	OTHER IMAGING SERVICES-ULTRASOUND
403	Require CPT, Assign APG 308	OTHER IMAGING SERVICES-SCREENING MAMMOGRAPHY (EFFECTIVE 1/1/91)
404	Require CPT, Assign APG 306	OTHER IMAGING SERVICES-PET SCANS
409	Require CPT-4	OTHER IMAGING SERVICES-OTHER
410	Require CPT, Assign APG 057	RESPIRATORY SERVICES-GENERAL CLASSIFICATION
412	Require CPT, Assign APG 057	RESPIRATORY SERVICES-INHALATION SERVICES
413	Allocate	RESPIRATORY SERVICES-HYPERBARIC OXYGEN THERAPY

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
419	Require CPT, Assign APG 057	RESPIRATORY SERVICES-OTHER
420	Require CPT, Assign APG 272	PHYSICAL THERAPY-GENERAL CLASSIFICATION
421	Require CPT, Assign APG 272	PHYSICAL THERAPY-VISIT CHARGE
422	Require CPT, Assign APG 272	PHYSICAL THERAPY-HOURLY CHARGE
423	Require CPT, Assign APG 272	PHYSICAL THERAPY-GROUP RATE
424	Require CPT, Assign APG 272	PHYSICAL THERAPY-EVALUATION OR RE-EVALUATION
429	Require CPT, Assign APG 272	PHYSICAL THERAPY-OTHER
430	Require CPT, Assign APG 271	OCCUPATIONAL THERAPY-GENERAL CLASSIFICATION
431	Require CPT, Assign APG 271	OCCUPATIONAL THERAPY-VISIT CHARGE
432	Require CPT, Assign APG 271	OCCUPATIONAL THERAPY-HOURLY CHARGE
433	Require CPT, Assign APG 271	OCCUPATIONAL THERAPY-GROUP RATE
434	Require CPT, Assign APG 271	OCCUPATIONAL THERAPY-EVALUATION OR RE-EVALUATION
439	Require CPT, Assign APG 271	OCCUPATIONAL THERAPY-OTHER (MAY INCLUDE RESTORATIVE THERAPY)
440	Require CPT, Assign APG 273	SPEECH-LANGUAGE PATHOLOGY-GENERAL CLASSIFICATION
441	Require CPT, Assign APG 273	SPEECH-LANGUAGE PATHOLOGY-VISIT CHARGE
442	Require CPT, Assign APG 273	SPEECH-LANGUAGE PATHOLOGY-HOURLY CHARGE
443	Require CPT, Assign APG 273	SPEECH-LANGUAGE PATHOLOGY-GROUP RATE
444	Require CPT, Assign APG 273	SPEECH-LANGUAGE PATHOLOGY-EVALUATION OR RE-EVALUATION
449	Require CPT, Assign APG 273	SPEECH-LANGUAGE PATHOLOGY-OTHER
450	Allocate	EMERGENCY ROOM-GENERAL CLASSIFICATION
459	Allocate	EMERGENCY ROOM-OTHER
460	Require CPT, Assign APG 371	PULMONARY FUNCTION-GENERAL CLASSI- FICATION
469	Require CPT, Assign APG 371	PULMONARY FUNCTION-OTHER
470	Require CPT, Assign APG 237	AUDIOLOGY-GENERAL CLASSIFICATION
471	Require CPT, Assign APG 237	AUDIOLOGY-DIAGNOSTIC
472	Require CPT, Assign APG 237	AUDILOGY-TREATMENT

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
479	Require CPT, Assign APG 237	AUDIOLOGY-OTHER
480	Require CPT-4	CARDILOGY-GENERAL CLASSIFICATION
481	Require CPT, Assign APG 076	CARDILOGY-CARDIAC CATH LAB
482	Require CPT, Assign APG 071	CARDILOGY-STRESS TEST
489	Require CPT-4	CARDILOGY-OTHER
490	Allocate SP Only	AMBULATORY SURGICAL CARE-GENERAL CLASSIFICATION
499	Allocate SP Only	AMBULATORY SURGICAL CARE-OTHER
500	Error	OUTPATIENT SERVICES - GENERAL CLASSIFICATION
509	Error	OUTPATIENT SERVICES - OTHER
510	Allocate	CLINIC - GENERAL CLASSIFICATION
511	Allocate	CLINIC - CHRONIC PAIN CENTER
512	Allocate	CLINIC - DENTAL CENTER
513	Allocate	CLINIC - PSYCHIATRIC
514	Allocate	CLINIC - OB-GYN
515	Allocate	CLINIC - PEDIATRIC
519	Allocate	CLINIC - OTHER
520	Allocate	FREE-STANDING CLINIC GENERAL CLSFCTN
521	Allocate	FREE-STANDING CLINIC-RURAL HEALTH- CLINIC
522	Allocate	FREE-STANDING CLINIC-RURAL HEALTH-HOME
523	Allocate	FREE-STANDING CLINIC-FAMILY PRACTICE
529	Allocate	FREE-STANDING CLINIC-OTHER
530	Allocate	OSTEOPATHIC SERVICES-GENERAL CLASSIFICATION
531	Allocate	OSTEOPATHIC SERVICES-OSTEOPATHIC THERAPY
539	Allocate	OSTEOPATHIC SERVICES-OTHER
540	Exclude	AMBULANCE-GENERAL CLASSIFICATION
541	Exclude	AMBULANCE-SUPPLIES
542	Exclude	AMBULANCE-MEDICAL TRANSPORT
543	Exclude	AMBULANCE-HEART MOBILE
544	Exclude	AMBULANCE-OXYGEN
545	Exclude	AMBULANCE-AIR AMBULANCE
546	Exclude	AMBULANCE-NEO-NATAL AMBULANCE
547	Exclude	AMBULANCE-PHARMACY
548	Exclude	AMBULANCE-TELEPHONE TRANSMISSION EKG
549	Exclude	AMBULANCE-OTHER
550	Error	SKILLED NURSING-GENERAL CLASSIFICATION
551	Error	SKILLED NURSING-VISIT CHARGE
552	Error	SKILLED NURSING-HOURLY CHARGE
559	Error	SKILLED NURSING-OTHER
560	Allocate	MEDICAL SOCIAL SERVICES-GENERAL CLASSIFICATION
561	Allocate	MEDICAL SOCIAL SERVICES-VISIT CHARGE
562	Allocate	MEDICAL SOCIAL SERVICES-HOURLY CHARGES
569	Allocate	MEDICAL SOCIAL SERVICES-OTHER
570	Error	HOME HEALTH AID (HOME HEALTH)-GENERAL CLASSIFICATION
571	Error	HOME HEALTH AID (HOME HEALTH)-VISIT CHARGE

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
572	Error	HOME HEALTH AID (HOME HEALTH)-HOURLY CHARGE
579	Error	HOME HEALTH AID (HOME HEALTH)-OTHER
580	Error	OTHER VISITS (HOME HEALTH)-GENERAL CLASSIFICATION
581	Error	OTHER VISITS (HOME HEALTH)-VISIT CHARGE
582	Error	OTHER VISITS (HOME HEALTH)-HOURLY CHARGE
589	Error	OTHER VISITS (HOME HEALTH)-OTHER
590	Error	UNITS OF SERVICE (HOME HEALTH)-GENERAL CLASSIFICATION
599	Error	UNITS OF SERVICE (HOME HEALTH)-OTHER
600	Error	OXYGEN - GENERAL CLASSIFICATION
601	Error	OXYGEN - STAT OR PORT EQUIP/SUPPLY OR COUNT
602	Error	OXYGEN - STAT/EQUIP/UNDER 1 LPM
603	Error	OXYGEN - STAT/EQUIP/OVER 4 LPM
604	Error	OXYGEN - STAT/EQUIP/PORTABLE ADD-ON
610	Require CPT, Assign APG 306	MAGNETIC RESONANCE IMAGING (MRI) - GENERAL CLASSIFICATION
611	Require CPT, Assign APG 306	MRI-BRAIN (INCLUDING BRAINSTEM)
612	Require CPT, Assign APG 306	MRI-SPINAL CORD (INCLUDING SPINE)
619	Require CPT, Assign APG 306	MRI-OTHER
621	Allocate	MEDICAL/SURGICAL SUPPLIES - SUPPLIES INCIDENT TO RADIOLOGY
622	Allocate	MEDICAL/SURGICAL SUPPLIES - SUPPLIES INCIDENT TO OTHER DIAGNOSTIC SERVICES
630	Exclude	DRUGS - GENERAL CLASSIFICATION
631	Exclude	DRUGS - SINGLE SOURCE DRUG
633	Exclude	DRUGS - MULTIPLE SOURCE DRUGS - RESTRICTIVE PRESCRIPTION
634	Allocate	DRUGS - EPOETIN - UNDER 10,000 UNITS
635	Allocate	DRUGS - EPOETIN - 10,000 OR MORE
636	Allocate	DRUGS - REQUIRING DETAILED CODING
640	Error	HOME IV THERAPY SVCS - GENERAL CLASSIFICATION
641	Error	HOME IV THERAPY SVCS - NONROUTINE NURSING, CENTRAL LINE
642	Error	HOME IV THERAPY SVCS - IV SITE CARE, CENTRAL LINE
643	Error	HOME IV THERAPY SVCS - IV START/CHANGE, PERIPHERAL LINE
644	Error	HOME IV THERAPY SVCS - NONROUTINE NURSING PERIPHERAL LINE
645	Error	HOME IV THERAPY SVCS - TRAINING PATIENT/CAREGIVER, CENTRAL LINE
646	Error	HOME IV THERAPY SVCS - TRAINING DISABLED PATIENT, CENTRAL LINE
647	Error	HOME IV THERAPY SVCS - TRAINING PATIENT/CAREGIVER, PERIPHERAL LINE
648	Error	HOME IV THERAPY SVCS - TRAINING DISABLED PATIENT, PERIPHERAL LINE
649	Error	HOME IV THERAPY SVCS - OTHER IV THERAPY SERVICES
650	Error	HOSPICE SERVICES-GENERAL CLASSIFICATION
651	Error	HOSPICE SERVICES-ROUTINE HOME CARE
652	Error	HOSPICE SERVICES-CONTINUOUS HOME CARE - 1/2
655	Error	HOSPICE SERVICES-INPATIENT CARE
656	Error	HOSPICE SERVICES-GENERAL INPATIENT CARE (NON-RESPITE)
657	Error	HOSPICE SERVICES-PHYSICIAN SERVICES
659	Error	HOSPICE SERVICES-OTHER

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
700	Allocate	CAST ROOM-GENERAL CLASSIFICATION
709	Allocate	CAST ROOM-OTHER
710	Allocate SP Only	RECOVERY ROOM-GENERAL CLASSIFICATION
719	Allocate SP Only	RECOVERY ROOM-OTHER
720	Require CPT-4	LABOR ROOM/DELIVERY-GENERAL CLASSIFICATION
721	Require CPT-4	LABOR ROOM/DELIVERY-LABOR
722	Require CPT-4	LABOR ROOM/DELIVERY-DELIVERY
723	Require CPT-4	LABOR ROOM/DELIVERY-CIRCUMCISION
724	Require CPT-4	LABOR ROOM/DELIVERY-BIRTHING CENTER
729	Require CPT-4	LABOR ROOM/DELIVERY-OTHER
730	Require CPT, Assign APG 373	EKG/ECG (ELECTROCARDIOGRAM)-GENERAL CLASSIFICATION
731	Require CPT, Assign APG 378	EKG/ECG (ELECTROCARDIOGRAM)-HOLTER MONITOR
732	Require CPT-4	EKG/ECG (ELECTROCARDIOGRAM)-TELEMETRY (INCLUDES FETAL MONITORING)
739	Require CPT, Assign APG 373	EKG/ECG (ELECTROCARDIOGRAM)-OTHER
740	Require CPT, Assign APG 192	EEG (ELECTROENCEPHALOGRAM)-GENERAL CLASSIFICATION
749	Require CPT, Assign APG 192	EEG (ELECTROENCEPHALOGRAM)-OTHER
750	Allocate SP Only	GASTRO-INTESTINAL SERVICES-GENERAL CLASSIFICATION
759	Allocate SP Only	GASTRO-INTESTINAL SERVICES-OTHER
760	Allocate	TREATMENT OR OBSERVATION ROOM-GENERAL CLASSIFICATION
761	Allocate	TREATMENT OR OBSERVATION ROOM-TREATMENT ROOM
762	Allocate	TREATMENT OR OBSERVATION ROOM-OBSERVATION ROOM
769	Allocate	TREATMENT OR OBSERVATION ROOM-OTHER TREATMENT/OBSERVATION ROOM
790	Require CPT, Assign APG 131	LITHOTRIPSY-GENERAL CLASSIFICATION
799	Require CPT, Assign APG 131	LITHOTRIPSY-OTHER
800	Error	INPATIENT RENAL DIALYSIS - GENERAL CLASSIFICATION
801	Error	INPATIENT RENAL DIALYSIS - INPATIENT HEMODIALYSIS
802	Error	INPATIENT RENAL DIALYSIS - INPATIENT PERITONEAL (NON-CAPD)
803	Error	INPATIENT RENAL DIALYSIS - INPATIENT CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)
804	Error	INPATIENT RENAL DIALYSIS - INPATIENT CONTINUOUS CYCLING PERITONEAL DIALYSIS (CCPD)
809	Error	INPATIENT RENAL DIALYSIS - OTHER INPATIENT DIALYSIS
810	Error	ORGAN ACQUISITION - GENERAL CLASSIFICATION
811	Error	ORGAN ACQUISITION - LIVING DONOR-KIDNEY
812	Error	ORGAN ACQUISITION - CADAVER DONOR KIDNEY
813	Error	ORGAN ACQUISITION-UNKNOWN DONOR-KIDNEY
814	Error	ORGAN ACQUISITION-OTHER KIDNEY ACQUISITION
815	Error	ORGAN ACQUISITION-CADAVER DONOR-HEART
816	Error	ORGAN ACQUISITION-OTHER HEART ACQUISITION
817	Error	ORGAN ACQUISITION-DONOR-LIVER
819	Error	ORGAN ACQUISITION-OTHER

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
820	Require CPT, Assign APG 139	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-GENERAL CLASSIFICATION
821	Require CPT, Assign APG 139	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HEMODIALYSIS/COMPOSITE OR OTHER RATE
822	Require CPT, Assign APG 139	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HOME SUPPLIES
823	Require CPT, Assign APG 139	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HOME EQUIPMENT
824	Require CPT, Assign APG 139	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-MAINTENANCE/100%
825	Require CPT, Assign APG 139	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-SUPPORT SERVICES
829	Require CPT, Assign APG 139	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-OTHER
830	Require CPT, Assign APG 140	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- GENERAL CLASSIFICATION
831	Require CPT, Assign APG 140	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- PERITONEAL/COMPOSITE OR OTHER RATE
832	Require CPT, Assign APG 140	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- HOME SUPPLIES
833	Require CPT, Assign APG 140	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- HOME EQUIPMENT
834	Require CPT, Assign APG 140	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- MAINTENANCE/100%
835	Require CPT, Assign APG 140	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- SUPPORT SERVICES
839	Require CPT, Assign APG 140	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- OTHER
840	Require CPT, Assign APG 140	CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)-OUTPATIENT-GENERAL CLASSIFICATION
841	Require CPT, Assign APG 140	CAPD - OUTPATIENT - CAPD/COMPOSITE OR OTHER RATE
842	Require CPT, Assign APG 140	CAPD - OUTPATIENT - HOME SUPPLIES
843	Require CPT, Assign APG 140	CAPD - OUTPATIENT - HOME EQUIPMENT
844	Require CPT, Assign APG 140	CAPD - OUTPATIENT - MAINTENANCE/100%
845	Require CPT, Assign APG 140	CAPD - OUTPATIENT - SUPPORT SERVICES
849	Require CPT, Assign APG 140	CAPD - OUTPATIENT - OTHER
850	Require CPT, Assign APG 140	CONTINUOUS CYCLING PERITONEAL DIALYSIS (CCPD) - OUTPATIENT - GENERAL CLASSIFICATION
85●	Require CPT, Assign APG 140	CCPD - OUTPATIENT - CCPD/COMPOSITE OR OTHER RATE
852	Require CPT, Assign APG 140	CCPD - OUTPATIENT - HOME SUPPLIES
853	Require CPT, Assign APG 140	CCPD - OUTPATIENT - HOME EQUIPMENT

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
854	Require CPT, Assign APG 140	CCPD - OUTPATIENT - MAINTENANCE/100%
855	Require CPT, Assign APG 140	CCPD - OUTPATIENT - SUPPORT SERVICES
859	Require CPT, Assign APG 140	CCPD - OUTPATIENT - OTHER
880	Require CPT, Assign APG 139	MISCELLANEOUS DIALYSIS-GENERAL CLASSIFICATION
881	Require CPT, Assign APG 139	MISCELLANEOUS DIALYSIS-ULTRAFILTRATION
882	Error	MISCELLANEOUS DIALYSIS-HOME DIALYSIS AID VISIT
889	Require CPT, Assign APG 139	MISCELLANEOUS DIALYSIS-OTHER
890	Error	OTHER DONOR BANK-GENERAL CLASSIFICATION
891	Error	OTHER DONOR BANK-BONE
892	Error	OTHER DONOR BANK-ORGAN (OTHER THAN KIDNEY)
893	Error	OTHER DONOR BANK-SKIN
899	Error	OTHER DONOR BANK-OTHER
900	Allocate	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS- GENERAL CLASSIFICATION
901	Require CPT, Assign APG 193	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS- ELECTROSHOCK TREATMENT
902	Allocate	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS- MILIEU THERAPY
903	Allocate	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS- PLAY THERAPY
909	Allocate	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS - OTHER
910	Allocate	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - GENERAL CLASSIFICATION
911	Allocate	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - REHABILITATION
912	Allocate	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - DAY CARE
913	Allocate	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - NIGHT CARE
914	Require CPT, Assign APG 286	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - INDIVIDUAL THERAPY
915	Require CPT, Assign APG 289	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - GROUP THERAPY
916	Require CPT, Assign APG 288	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - FAMILY THERAPY
917	Allocate	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - BIOFEEDBACK
918	Allocate	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - TESTING
919	Allocate	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - OTHER
920	RequireCPT-4	OTHER DIAGNOSTIC SERVICES-GENERAL CLASSIFICATION
921	RequireCPT-4	OTHER DIAGNOSTIC SERVICES-PERIPHERAL VASCULAR LAB
922	Require CPT, Assign APG 194	OTHER DIAGNOSTIC SERVICES - ELECTROMYELOGRAM
923	Require CPT, Assign APG 333	OTHER DIAGNOSTIC SERVICES - PAP SMEAR
924	Require CPT, Assign APG 096	OTHER DIAGNOSTIC SERVICES-ALLERGY TEST
925	RequireCPT-4	OTHER DIAGNOSITC SERVICES-PREGNANCY TEST
929	RequireCPT-4	OTHER DIAGNOSTIC SERVICES - OTHER
940	Allocate	OTHER THERAPEUTIC SERVICES-GENERAL CLASSIFICATION
941	Allocate	OTHER THERAPEUTIC SERVICES-RECREATIONAL THERAPY

RC	RCA ACTION	REVENUE CENTER DESCRIPTION
942	Allocate	OTHER THERAPEUTIC SERVICES-EDUCATION/ TRAINING (INCLUDES DIABETES RELATED DIETARY THERAPY)
943	Allocate	OTHER THERAPEUTIC SERVICES-CARDIAC REHABILITATION
944	Require CPT, Assign APG 287	OTHER THERAPEUTIC SERVICES-DRUG REHABILITATION
945	Require CPT, Assign APG 287	OTHER THERAPEUTIC SERVICES-ALCOHOL REHABILITATION
946	Error	OTHER THERAPEUTIC SERVICES-ROUTINE COMPLEX MEDICAL EQUIPMENT
947	Error	ANCILLARY COMPLEX MEDICAL EQUIPMENT
949	Require CPT-4	OTHER THERAPEUTIC SERVICES-OTHER
960	Exclude	PROFESSIONAL FEES-GENERAL CLASSIFICATION
961	Exclude	PROFESSIONAL FEES-PSYCHIATRIC
962	Exclude	PROFESSIONAL FEES-OPTHALMOLOGY
963	Exclude	PROFESSIONAL FEES-ANESTHESIOLOGIST (MD)
964	Exclude	PROFESSIONAL FEES-ANESTHESTIST (CRNA)
969	Exclude	PROFESSIONAL FEES-OTHER
971	Exclude	PROFESSIONAL FEES-LABORATORY
972	Exclude	PROFESSIONAL FEES-RADIOLOGY-DIAGNOSTIC
973	Exclude	PROFESSIONAL FEES-RADIOLOGY-THERAPEUTIC
974	Exclude	PROFESSIONAL FEES-NUCLEAR MEDICINE
975	Exclude	PROFESSIONAL FEES-OPERATING ROOM
976	Exclude	PROFESSIONAL FEES-RESPIRATORY THERAPY
977	Exclude	PROFESSIONAL FEES-PHYSICAL THERAPY
978	Exclude	PROFESSIONAL FEES-OCCUPATIONAL THERAPY
979	Exclude	PROFESSIONAL FEES-SPEECH PATHOLOGY
981	Exclude	PROFESSIONAL FEES-EMERGENCY ROOM
982	Exclude	PROFESSIONAL FEES-OUTPATIENT SERVICES
983	Exclude	PROFESSIONAL FEES-CLINIC
984	Exclude	PROFESSIONAL FEES-MEDICAL SOCIAL SERVICES
985	Exclude	PROFESSIONAL FEES-EKG
986	Exclude	PROFESSIONAL FEES-EEG
987	Exclude	PROFESSIONAL FEES-HOSPITAL VISIT
988	Exclude	PROFESSIONAL FEES-CONSULTATION
989	Exclude	PROFESSIONAL FEES-PRIVATE DUTY NURSE
990	Exclude	PATIENT CONVENIENCE ITEMS-GENERAL CLASSIFICATION
991	Exclude	PATIENT CONVENIENCE ITEMS-CAFETERIA/ GUEST TRAY
992	Exclude	PATIENT CONVENIENCE ITEMS-PRIVATE LINEN SERVICE
993	Exclude	PATIENT CONVENIENCE ITEMS-TELEPHONE/ TELEGRAPH
994	Exclude	PATIENT CONVENIENCE ITEMS-TV/RADIO
995	Exclude	PATIENT CONVENIENCE ITEMS-NONPATIENT ROOM RENTALS
996	Exclude	PATIENT CONVENIENCE ITEMS-LATE DISCHARGE CHARGE
997	Exclude	PATIENT CONVENIENCE ITEMS-ADMISSION KITS
996	Exclude	PATIENT CONVENIENCE ITEMS-BEAUTY SHOP/ BARBER
999	Exclude	PATIENT CONVENIENCE ITEMS-OTHER

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APPENDIX G

Revenue Center to Department Mapping

RC	RC Description	Dept	Description
250	PHARMACY-GENERAL CLASSIFICATION	5600	Drugs Charged to Patients
251	PHARMACY-GENERIC DRUGS	5600	Drugs Charged to Patients
252	PHARMACY-NONGENERIC DRUGS	5600	Drugs Charged to Patients
253	PHARMACY-TAKE HOME DRUGS	5600	Drugs Charged to Patients
254	PHARMACY-DRUGS INCIDENT TO OTHER DIAGNOSTIC SERVICES	5600	Drugs Charged to Patients
255	PHARMACY-DRUGS INCIDENT TO RADIOLOGY	5600	Drugs Charged to Patients
256	PHARMACY-EXPERIMENTAL DRUGS	5600	Drugs Charged to Patients
257	PHARMACY-NON-PRESCRIPTION	5600	Drugs Charged to Patients
258	PHARMACY-IV SOLUTIONS	5600	Drugs Charged to Patients
259	PHARMACY-OTHER PHARMACY	5600	Drugs Charged to Patients
260	IV THERAPY-GENERAL CLASSIFICATION	4800	Intravenous Therapy
261	IV THERAPY-INFUSION PUMP	4800	Intravenous Therapy
262	IV THERAPY-PHARMACY SVCS	4800	Intravenous Therapy
263	IV THERAPY-DRUG/SUPPLY DELIVERY	4800	Intravenous Therapy
264	IV THERAPY-SUPPLIES	4800	Intravenous Therapy
269	IV THERAPY-OTHER IV THERAPY	4800	Intravenous Therapy
270	MEDICAL/SURGICAL SUPPLIES-GENERAL CLASSIFICATION	5500	Medical Supplies
271	MEDICAL/SURGICAL SUPPLIES-NONSTERILE SUPPLY	5500	Medical Supplies
272	MEDICAL/SURGICAL SUPPLIES-STERILE SUPPLY	5500	Medical Supplies
273	MEDICAL/SURGICAL SUPPLIES-TAKE HOME SUPPLIES	5500	Medical Supplies
274	MEDICAL/SURGICAL SUPPLIES-PROSTHETIC/ ORTHOTIC DEVICES	3540 5500	Prosthetic Medical Supplies
275	MEDICAL/SURGICAL SUPPLIES-PACE MAKER	3540 5500	Prosthetic Medical Supplies
276	MEDICAL/SURGICAL SUPPLIES-INTRAOCULAR LENS	3540 5500	Prosthetic Medical Supplies
277	MEDICAL/SURGICAL SUPPLIES-OXYGEN-TAKE HOME	5500	Medical Supplies
278	MEDICAL/SURGICAL SUPPLIES-OTHER IMPLANTS	5500	Medical Supplies
279	MEDICAL/SURGICAL SUPPLIES-OTHER DEVICES	5500	Medical Supplies
280	ONCOLOGY-GENERAL CLASSIFICATION	3480	Oncology
289	ONCOLOGY-OTHER ONCOLOGY	3480	Oncology
290	DURABLE MEDICAL EQUIPMENT(DME) - (OTHER THAN RENAL)-GENERAL CLASSIFICATION	6500 5500	Durable Medical Equipment – Rented Medical Supplies
291	DME (OTHER THAN RENAL) - RENTAL	6500 5500	Durable Medical Equipment – Rented Medical Supplies
292	DME (OTHER THAN RENAL) - PURCHASE OF NEW DME	6600 5500	Durable Medical Equipment – Sold Medical Supplies
293	DME (OTHER THAN RENAL) - PURCHASE OF USED DME	6600 5500	Durable Medical Equipment – Sold Medical Supplies

RC	RC Description	Dept	Description
294	DME (OTHER THAN RENAL) - SUPPLIES/DRUGS FOR DME EFFECTIVENESS (HHA ONLY)	EXCL	
299	DME (OTHER THAN RENAL) - OTHER	6500	Durable Medical Equipment – Rented
		5500	Medical Supplies
300	LABORATORY-GENERAL CLASSIFICATION	3390	Lab - Clinic
		4400	Laboratory
301	LABORATORY-CHEMISTRY	3180	Chemistry
		3390	Lab - Clinic
		4400	Laboratory
302	LABORATORY-IMMUNOLOGY	3390	Lab - Clinic
		4400	Laboratory
303	LABORATORY-RENAL PATIENT (HOME)	EXCL	
304	LABORATORY-NON-ROUTINE DIALYSIS	3390	Lab - Clinic
		4400	Laboratory
305	LABORATORY-HEMATOLOGY	3350	Hematology
		3390	Lab - Clinic
		4400	Laboratory
306	LABORATORY-BACTERIOLOGY & MICROBIOLOGY	3350	Hematology
		3390	Lab - Clinic
		4400	Laboratory
307	LABORATORY-UROLOGY	3390	Lab - Clinic
		4400	Laboratory
309	LABORATORY-OTHER LABORATORY	3390	Lab - Clinic
		4400	Laboratory
310	LABORATORY PATHOLOGICAL-GENERAL CLASSIFICATION	3420	Lab - Pathalogical
		4400	Laboratory
311	LABORATORY PATHOLOGICAL-CYTOLOGY	3240	Cytology
		3420	Lab - Pathalogical
		4400	Laboratory
312	LABORATORY PATHOLOGICAL-HISTOLOGY	3360	Histology
		3420	Lab - Pathalogical
		4400	Laboratory
314	LABORATORY PATHOLOGICAL-BIOPSY	3060	Biopsy
		3420	Lab - Pathalogical
		4400	Laboratory
319	LABORATORY PATHOLOGICAL-OTHER	3420	Lab - Pathalogical
		4400	Laboratory
320	RADIOLOGY-DIAGNOSIC-GENERAL CLASSIFICATION	4100	Radiology-Diagnostic
321	RADIOLOGY-DIAGNOSTIC-ANGIOCARDIOGRAPHY	3030	Angiocardiography
		4100	Radiology-Diagnostic
322	RADIOLOGY-DIAGNOSTIC-ARTHROGRAPHY	4100	Radiology-Diagnostic
323	RADIOLOGY-DIAGNOSTIC-ARTERIOGRAPHY	4100	Radiology-Diagnostic
324	RADIOLOGY-DIAGNOSTIC-CHEST X-RAY	4100	Radiology-Diagnostic
329	RADIOLOGY-DIAGNOSTIC-OTHER	4100	Radiology-Diagnostic
330	RADIOLOGY-THERAPEUTIC-GENERAL CLASSIFICATION	4200	Radiology-Therapeutic
		4100	Radiology-Diagnostic

RC	RC Description	Dept	Description
331	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-INJECTED	4200	Radiology-Therapeutic
		4100	Radiology-Diagnostic
332	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY- ORAL	4200	Radiology-Therapeutic
		4100	Radiology-Diagnostic
333	RADIOLOGY-THERAPEUTIC-RADIATION THERAPY	4200	Radiology-Therapeutic
		4100	Radiology-Diagnostic
335	RADIOLOGY-THERAPEUTIC-CHEMOTHERAPY-IV	4200	Radiology-Therapeutic
		4100	Radiology-Diagnostic
339	RADIOLOTY-THERAPEUTIC-OTHER	4200	Radiology-Therapeutic
		4100	Radiology-Diagnostic
340	NUCLEAR MEDICINE-GENERAL CLASSIFICATION	4300	Radioisotope
		4100	Radiology-Diagnostic
341	NUCLEAR MEDICINE-DIAGNOSTIC	3450	Nuclear Med - Diagnostic
		4300	Radioisotope
		4100	Radiology-Diagnostic
342	NUCLEAR MEDICINE-THERAPEUTIC	3470	Nuclear Med - Therapeutic
		4300	Radioisotope
		4100	Radiology-Diagnostic
349	NUCLEAR MEDICINE-OTHER	4300	Radioisotope
		4100	Radiology-Diagnostic
350	COMPUTED TOMOGRAPHIC (CT) SCAN-GENERAL CLASSIFICATION	3230	CAT Scan
351	CT SCAN-HEAD SCAN	3230	CAT Scan
352	CT SCAN-BODY SCAN	3230	CAT Scan
359	CT SCAN-OTHER CT SCANS	3230	CAT Scan
360	OPERATING ROOM SERVICES-GENERAL CLASSIFICATION	3700	Operating Room
361	OPERATING ROOM SERVICES-MINOR SURGERY	3700	Operating Room
362	OPERATING ROOM SERVICES-ORGAN TRANSPLANT-OTHER THAN KIDNEY	3700	Operating Room
367	OPERATING ROOM SERVICES-KIDNEY TRANSPLANT	3700	Operating Room
369	OPERATING ROOM SERVICES-OTHER OPERATING ROOM SERVICES	3700	Operating Room
370	ANESTHESIA-GENERAL CLASSIFICATION	4000	Anesthesiology
371	ANESTHESIA-INCIDENT TO RAD	4000	Anesthesiology
372	ANESTHESIA-INCIDENT TO OTHER DIAGNOSTIC SERVICES	4000	Anesthesiology
374	ANESTHESIA-ACUPUNCTURE	EXCL	
379	ANESTHESIA-OTHER ANESTHESIA	4000	Anesthesiology
380	BLOOD-GENERAL CLASSIFICATION	4600	Whole Blood
381	BLOOD-PACKED RED CELLS	4600	Whole Blood
382	BLOOD-WHOLE BLOOD	4600	Whole Blood
383	BLOOD-PLASMA	4600	Whole Blood
384	BLOOD-PLATELETS	4600	Whole Blood
385	BLOOD-LEUCOCYTES	4600	Whole Blood
386	BLOOD-OTHER COMPONENTS	4600	Whole Blood
387	BLOOD-OTHER DERIVATIVES (CRYOPRICIPATATES)	4600	Whole Blood
389	BLOOD-OTHER BLOOD	4600	Whole Blood

RC	RC Description	Dept	Description
390	BLOOD STORAGE AND PROCESSING-GENERAL CLASSIFICATION	4700	Blood Storing, Processing
391	BLOOD STORAGE AND PROCESSING-BLOOD ADMINISTRATION	4700	Blood Storing, Processing
399	BLOOD STORAGE AND PROCESSING-OTHER BLOOD STORAGE AND PROCESSING	4700	Blood Storing, Processing
400	OTHER IMAGING SERVICES-GENERAL CLASSIFICATION	4100	Radiology-Diagnostic
401	OTHER IMAGING SERVICES-DIAGNOSTIC MAMMOGRAPHY	3440 4100	Mamography Radiology-Diagnostic
402	OTHER IMAGING SERVICES-ULTRASOUND	3630 4100	Ultra Sound Radiology-Diagnostic
403	OTHER IMAGING SERVICES-SCREENING MAMMOG-RAPHY (EFFECTIVE 1/1/91)	3440 4100	Mamography Radiology-Diagnostic
409	OTHER IMAGING SERVICES-OTHER	4100	Radiology-Diagnostic
410	RESPIRATORY SERVICES-GENERAL CLASSIFICATION	4900	Respiratory Therapy
412	RESPIRATORY SERVICES-INHALATION SERVICES	4900	Respiratory Therapy
413	RESPIRATORY SERVICES-HYPERBARIC OXYGEN THERAPY	4900	Respiratory Therapy
419	RESPIRATORY SERVICES-OTHER	4900	Respiratory Therapy
420	PHYSICAL THERAPY-GENERAL CLASSIFICATION	5000	Physical Therapy
421	PHYSICAL THERAPY-VISIT CHARGE	5000	Physical Therapy
422	PHYSICAL THERAPY-HOURLY CHARGE	5000	Physical Therapy
423	PHYSICAL THERAPY-GROUP RATE	5000	Physical Therapy
424	PHYSICAL THERAPY-EVALUATION OR RE-EVALUATION	5000	Physical Therapy
429	PHYSICAL THERAPY-OTHER	5000	Physical Therapy
430	OCCUPATIONAL THERAPY-GENERAL CLASSIFICATION	5100 5000	Occupatiional Therapy Physical Therapy
431	OCCUPATIONAL THERAPY-VISIT CHARGE	5100 5000	Occupatiional Therapy Physical Therapy
432	OCCUPATIONAL THERAPY-HOURLY CHARGE	5100 5000	Occupatiional Therapy Physical Therapy
433	OCCUPATIONAL THERAPY-GROUP RATE	5100 5000	Occupatiional Therapy Physical Therapy
439	OCCUPATIONAL THERAPY-OTHER (MAY INCLUDE RESTORATIVE THERAPY)	5100 5000	Occupatiional Therapy Physical Therapy
440	SPEECH-LANGUAGE PATHOLOGY-GENERAL CLASSIFICATION	5200 5000	Speech Pathology Physical Therapy
441	SPEECH-LANGUAGE PATHOLOGY-VISIT CHARGE	5200 5000	Speech Pathology Physical Therapy
442	SPEECH-LANGUAGE PATHOLOGY-HOURLY CHARGE	5200 5000	Speech Pathology Physical Therapy
443	SPEECH-LANGUAGE PATHOLOGY-GROUP RATE	5200 5000	Speech Pathology Physical Therapy

RC	RC Description	Dept	Description
444	SPEECH-LANGUAGE PATHOLOGY-EVALUATION OR RE-EVALUATION	5200	Speech Pathology
		5000	Physical Therapy
449	SPEECH-LANGUAGE PATHOLOGY-OTHER	5200	Speech Pathology
		5000	Physical Therapy
450	EMERGENCY ROOM-GENERAL CLASSIFICATION	6100	Emergency
459	EMERGENCY ROOM-OTHER	6100	Emergency
460	PULMONARY FUNCTION-GENERAL CLASSIFICATION	3560	Pulmonary Function
469	PULMONARY FUNCTION-OTHER	3560	Pulmonary Function
470	AUDIOLOGY-GENERAL CLASSIFICATION	3040	Audiology
		5200	Speech Pathology
		5000	Physical Therapy
471	AUDIOLOGY-DIAGNOSTIC	3040	Audiology
		5200	Speech Pathology
		5000	Physical Therapy
472	AUDILOGY-TREATMENT	3040	Audiology
		5200	Speech Pathology
		5000	Physical Therapy
479	AUDIOLOGY-OTHER	3040	Audiology
		5200	Speech Pathology
		5000	Physical Therapy
480	CARDILOGY-GENERAL CLASSIFICATION	3140	Cardiology
		5300	Electrocardiology
481	CARDILOGY-CARDIAC CATH LAB	3120	Cardiac Cath Lab
		3700	Operating Room
482	CARDILOGY-STRESS TEST	3620	Stress Test
		5300	Electrocardiology
489	CARDILOGY-OTHER	3140	Cardiology
		5300	Electrocardiology
490	AMBULATORY SURGICAL CARE-GENERAL CLASSIFICATION	5800	ASC (Non-distinct)
		3700	Operating Room
499	AMBULATORY SURGICAL CARE-OTHER	5800	ASC (Non-distinct)
		3700	Operating Room
500	OUTPATIENT SERVICES - GENERAL CLASSIFICATION	EXCL	
509	OUTPATIENT SERVICES - OTHER	EXCL	
510	CLINIC - GENERAL CLASSIFICATION	6000	Clinic
511	CLINIC - CHRONIC PAIN CENTER	6000	Clinic
512	CLINIC - DENTAL CENTER	6000	Clinic
513	CLINIC - PSYCHIATRIC	6000	Clinic
514	CLINIC - OB-GYN	6000	Clinic
515	CLINIC - PEDIATRIC	6000	Clinic
519	CLINIC - OTHER	6000	Clinic
520	FREE-STANDING CLINIC GENERAL CLSFCTN	6000	Clinic
521	FREE-STANDING CLINIC-RURAL HEALTH- CLINIC	6000	Clinic
522	FREE-STANDING CLINIC-RURAL HEALTH-HOME	EXCL	
523	FREE-STANDING CLINIC-FAMILY PRACTICE	4040	Family Practice
		6000	Clinic
529	FREE-STANDING CLINIC-OTHER	6000	Clinic

RC	RC Description	Dept	Description
530	OSTEOPATHIC SERVICES-GENERAL CLASSIFICATION	3530	COST CENTER 3530
531	OSTEOPATHIC SERVICES-OSTEOPATHIC THERAPY	3530	COST CENTER 3530
539	OSTEOPATHIC SERVICES-OTHER	3530	COST CENTER 3530
540	AMBULANCE-GENERAL CLASSIFICATION	EXCL	
541	AMBULANCE-SUPPLIES	EXCL	
542	AMBULANCE-MEDICAL TRANSPORT	EXCL	
543	AMBULANCE-HEART MOBILE	EXCL	
544	AMBULANCE-OXYGEN	EXCL	
545	AMBULANCE-AIR AMBULANCE	EXCL	
546	AMBULANCE-NEO-NATAL AMBULANCE	EXCL	
549	AMBULANCE-OTHER	EXCL	
550	SKILLED NURSING-GENERAL CLASSIFICATION	EXCL	
551	SKILLED NURSING-VISIT CHARGE	EXCL	
552	SKILLED NURSING-HOURLY CHARGE	EXCL	
559	SKILLED NURSING-OTHER	EXCL	
560	MEDICAL SOCIAL SERVICES-GENERAL CLASSIFICATION		
561	MEDICAL SOCIAL SERVICES-VISIT CHARGE		
562	MEDICAL SOCIAL SERVICES-HOURLY CHARGES		
569	MEDICAL SOCIAL SERVICES-OTHER		
570	HOME HEALTH AID (HOME HEALTH)-GENERAL CLASSIFICATION	EXCL	
571	HOME HEALTH AID (HOME HEALTH)-VISIT CHARGE	EXCL	
572	HOME HEALTH AID (HOME HEALTH)-HOURLY CHARGE	EXCL	
579	HOME HEALTH AID (HOME HEALTH)-OTHER	EXCL	
580	OTHER VISITS (HOME HEALTH)-GENERAL CLASSIFICATION	EXCL	
581	OTHER VISITS (HOME HEALTH)-VISIT CHARGE	EXCL	
582	OTHER VISITS (HOME HEALTH)-HOURLY CHARGE	EXCL	
589	OTHER VISITS (HOME HEALTH)-OTHER	EXCL	
590	UNITS OF SERVICE (HOME HEALTH)-GENERAL CLASSIFICATION	EXCL	
599	UNITS OF SERVICE (HOME HEALTH)-OTHER	EXCL	
600	OXYGEN - GENERAL CLASSIFICATION	EXCL	
601	OXYGEN - STAT OR PORT EQUIP/SUPPLY OR COUNT	EXCL	
602	OXYGEN - STAT/EQUIP/UNDER 1 LPM	EXCL	
603	OXYGEN - STAT/EQUIP/OVER 4 LPM	EXCL	
604	OXYGEN - STAT/EQUIP/PORTABLE ADD-ON	EXCL	
610	MAGNETIC RESONANCE IMAGING (MRI) - GENERAL CLASSIFICATION	4100	Radiology-Diagnostic
611	MRI-BRAIN (INCLUDING BRAINSTEM)	4100	Radiology-Diagnostic
612	MRI-SPINAL CORD (INCLUDING SPINE)	4100	Radiology-Diagnostic
619	MRI-OTHER	4100	Radiology-Diagnostic
621	MEDICAL/SURGICAL SUPPLIES - SUPPLIES INCIDENT TO RADIOLOGY	5500	Medical Supplies
622	MEDICAL/SURGICAL SUPPLIES - SUPPLIES INCIDENT TO OTHER DIAGNOSTIC SERVICES	5500	Medical Supplies
630	DRUGS - GENERAL CLASSIFICATION	EXCL	

RC	RC Description	Dept	Description
631	DRUGS - SINGLE SOURCE DRUG	EXCL	
633	DRUGS - MULTIPLE SOURCE DRUGS DRUGS - RESTRICTIVE PRESCRIPTION	EXCL	
634	DRUGS - EPOETIN - UNDER 10,000 UNITS	5600	Drugs Charged to Patients
635	DRUGS - EPOETIN - 10,000 OR MORE	5600	Drugs Charged to Patients
636	DRUGS - REQUIRING DETAILED CODING	5600	Drugs Charged to Patients
640	HOME IV THERAPY SVCS - GENERAL CLASSIFICATION	EXCL	
641	HOME IV THERAPY SVCS - NONROUTINE NURSING, CENTRAL LINE	EXCL	
642	HOME IV THERAPY SVCS - IV SITE CARE, CENTRAL LINE	EXCL	
643	HOME IV THERAPY SVCS - IV START/CHANGE, PERIPHERAL LINE	EXCL	
644	HOME IV THERAPY SVCS - NONROUTINE NURSING PERIPHERAL LINE	EXCL	
645	HOME IV THERAPY SVCS - TRAINING PATIENT/CAR-EGIVER, CENTRAL LINE	EXCL	
646	HOME IV THERAPY SVCS - TRAINING DISABLED PATIENT, CENTRAL LINE	EXCL	
647	HOME IV THERAPY SVCS - TRAINING PATIENT/CAR-EGIVER, PERIPHERAL LINE	EXCL	
648	HOME IV THERAPY SVCS - TRAINING DISABLED PATIENT, PERIPHERAL LINE	EXCL	
649	HOME IV THERAPY SVCS - OTHER IV THERAPY SERVICES	EXCL	
650	HOSPICE SERVICES-GENERAL CLASSIFICATION	EXCL	
651	HOSPICE SERVICES-ROUTINE HOME CARE	EXCL	
652	HOSPICE SERVICES-CONTINUOUS HOME CARE - 1/2	EXCL	
655	HOSPICE SERVICES-INPATIENT CARE	EXCL	
656	HOSPICE SERVICES-GENERAL INPATIENT CARE (NON-RESPITE)	EXCL	
657	HOSPICE SERVICES-PHYSICIAN SERVICES	EXCL	
659	HOSPICE SERVICES-OTHER	EXCL	
700	CAST ROOM-GENERAL CLASSIFICATION	6100	Emergency
709	CAST ROOM-OTHER	6100	Emergency
710	RECOVERY ROOM-GENERAL CLASSIFICATION	3800 3700	Recovery Room Operating Room
719	RECOVERY ROOM-OTHER	3800 3700	Recovery Room Operating Room
720	LABOR ROOM/DELIVERY-GENERAL CLASSIFICATION	3900	Delivery Room
721	LABOR ROOM/DELIVERY-LABOR	3900	Delivery Room
722	LABOR ROOM/DELIVERY-DELIVERY	3900	Delivery Room
723	LABOR ROOM/DELIVERY-CIRCUMCISION	3220	Circumcision
724	LABOR ROOM/DELIVERY-BIRTHING CENTER	3070 3900	Birthing Center Delivery Room
729	LABOR ROOM/DELIVERY-OTHER	3900	Delivery Room
730	EKG/ECG (ELECTROCARDIOGRAM)-GENERAL CLASSIFICATION	3280	EKG and EEG

RC	RC Description	Dept	Description
		5300	Electrocardiology
731	EKG/ECG (ELECTROCARDIOGRAM)-HOLTER MONITOR	3370	Holter Monitor
		5300	Electrocardiology
732	EKG/ECG (ELECTROCARDIOGRAM)-TELEMETRY (INCLUDES FETAL MONITORING)	3280	EKG and EEG
		5300	Electrocardiology
739	EKG/ECG (ELECTROCARDIOGRAM)-OTHER	3280	EKG and EEG
		5300	Electrocardiology
740	EEG (ELECTROENCEPHALOGRAM)-GENERAL CLASSIFICATION	5400	Electroencephalography
749	EEG (ELECTROENCEPHALOGRAM)-OTHER	5400	Electroencephalography
750	GASTRO-INTESTINAL SERVICES-GENERAL CLASSIFICATION	3340	Gastro Intestinal
759	GASTRO-INTESTINAL SERVICES-OTHER	3340	Gastro Intestinal
760	TREATMENT OR OBSERVATION ROOM-GENERAL CLASSIFICATION	6100	Emergency
761	TREATMENT OR OBSERVATION ROOM-TREATMENT ROOM	6100	Emergency
762	TREATMENT OR OBSERVATION ROOM-OBSERVATION ROOM	6100	Emergency
769	TREATMENT OR OBSERVATION ROOM-OTHER TREATMENT/OBSERVATION ROOM	6100	Emergency
790	LITHOTRIPSY-GENERAL CLASSIFICATION	3700	Operating Room
799	LITHOTRIPSY-OTHER	3700	Operating Room
800	INPATIENT RENAL DIALYSIS - GENERAL CLASSIFICATION	EXCL	
801	INPATIENT RENAL DIALYSIS - INPATIENT HEMODIALYSIS	EXCL	
802	INPATIENT RENAL DIALYSIS - INPATIENT PERITONEAL (NON-CAPD)	EXCL	
803	INPATIENT RENAL DIALYSIS - INPATIENT CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)	EXCL	
804	INPATIENT RENAL DIALYSIS - INPATIENT CONTINUOUS CYCLING PERITONEAL DIALYSIS (CCPD)	EXCL	
809	INPATIENT RENAL DIALYSIS - OTHER INPATIENT DIALYSIS	EXCL	
810	ORGAN ACQUISITION - GENERAL CLASSIFICATION	EXCL	
811	ORGAN ACQUISITION - LIVING DONOR-KIDNEY	EXCL	
812	ORGAN ACQUISITION - CADAVER DONOR KIDNEY	EXCL	
813	ORGAN ACQUISITION-UNKNOWN DONOR-KIDNEY	EXCL	
814	ORGAN ACQUISITION-OTHER KIDNEY ACQUISITION	EXCL	
815	ORGAN ACQUISITION-CADAVER DONOR-HEART	EXCL	
816	ORGAN ACQUISITION-OTHER HEART ACQUISITION	EXCL	
817	ORGAN ACQUISITION-DONOR-LIVER	EXCL	
819	ORGAN ACQUISITION-OTHER	EXCL	
820	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-GENERAL CLASSIFICATION	5700	Renal Dialysis
821	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HEMODIALYSIS/COMPOSITE OR OTHER RATE	5700	Renal Dialysis

RC	RC Description	Dept	Description
822	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HOME SUPPLIES	EXCL	
823	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-HOME EQUIPMENT	EXCL	
824	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-MAINTENANCE/100%	EXCL	
825	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-SUPPORT SERVICES	EXCL	
825	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-SUPPORT SERVICES	EXCL	
829	HEMODIALYSIS-OUTPATIENT OR HOME DIALYSIS-OTHER	EXCL	
830	PERITONEAL DIALYSIS-OUTPATIENT OR HOME-GENERAL CLASSIFICATION	5700	Renal Dialysis
831	PERITONEAL DIALYSIS-OUTPATIENT OR HOME-PERITONEAL/COMPOSITE OR OTHER RATE	5700	Renal Dialysis
832	PERITONEAL DIALYSIS-OUTPATIENT OR HOME-HOME SUPPLIES	EXCL	
833	PERITONEAL DIALYSIS-OUTPATIENT OR HOME-HOME EQUIPMENT	EXCL	
834	PERITONEAL DIALYSIS-OUTPATIENT OR HOME-MAINTENANCE/100%	EXCL	
835	PERITONEAL DIALYSIS-OUTPATIENT OR HOME- SUPPORT SERVICES	EXCL	
839	PERITONEAL DIALYSIS-OUTPATIENT OR HOME-OTHER	EXCL	
840	CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD)-OUTPATIENT-GENERAL CLASSIFICATION	5700	Renal Dialysis
841	CAPD - OUTPATIENT - CAPD/COMPOSITE OR OTHER RATE	5700	Renal Dialysis
842	CAPD - OUTPATIENT - HOME SUPPLIES	EXCL	
843	CAPD - OUTPATIENT - HOME EQUIPMENT	EXCL	
844	CAPD - OUTPATIENT - MAINTENANCE/100%	EXCL	
845	CAPD - OUTPATIENT - SUPPORT SERVICES	EXCL	
849	CAPD - OUTPATIENT - OTHER	EXCL	
850	CONTINUOUS CYCLING PERITONEAL DIALYSIS (CCPD) - OUTPATIENT - GENERAL CLASSIFICATION	5700	Renal Dialysis
851	CCPD - OUTPATIENT - CCPD/COMPOSITE OR OTHER RATE	5700	Renal Dialysis
852	CCPD - OUTPATIENT - HOME SUPPLIES	EXCL	
853	CCPD - OUTPATIENT - HOME EQUIPMENT	EXCL	
854	CCPD - OUTPATIENT - MAINTENANCE/100%	EXCL	
855	CCPD - OUTPATIENT - SUPPORT SERVICES	EXCL	
859	CCPD - OUTPATIENT - OTHER	EXCL	
880	MISCELLANEOUS DIALYSIS-GENERAL CLASSIFICATION	5700	Renal Dialysis
881	MISCELLANEOUS DIALYSIS-ULTRAFILTRATION	5700	Renal Dialysis
882	MISCELLANEOUS DIALYSIS-HOME DIALYSIS AID VISIT	EXCL	
889	MISCELLANEOUS DIALYSIS-OTHER	5700	Renal Dialysis
890	OTHER DONOR BANK-GENERAL CLASSIFICATION	EXCL	

RC	RC Description	Dept	Description
891	OTHER DONOR BANK-BONE	EXCL	
892	OTHER DONOR BANK-ORGAN (OTHER THAN KIDNEY)	EXCL	
893	OTHER DONOR BANK-SKIN	EXCL	
899	OTHER DONOR BANK-OTHER	EXCL	
900	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-GENERAL CLASSIFICATION	3550 5100 6000	Psych Services Occupatiional Therapy Clinic
901	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-ELECTROSHOCK TREATMENT	3320 3700	Electroshock Therapy Operating Room
902	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-MILIEU THERAPY	3550 5100 6000	Psych Services Occupatiional Therapy Clinic
903	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS-PLAY THERAPY	3550 5100 6000	Psych Services Occupatiional Therapy Clinic
909	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS - OTHER	3550 5100 6000	Psych Services Occupatiional Therapy Clinic
910	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - GENERAL CLASSIFICATION	3550 6000	Psych Services Clinic
911	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - REHABILITATION	3550 6000	Psych Services Clinic
912	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - DAY CARE	3550 6000	Psych Services Clinic
913	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - NIGHT CARE	3550 6000	Psych Services Clinic
914	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - INDIVIDUAL THERAPY	3550 6000	Psych Services Clinic
915	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - GROUP THERAPY	3550 6000	Psych Services Clinic
916	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - FAMILY THERAPY	3550 6000	Psych Services Clinic
917	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - BIOFEEDBACK	3550 6000	Psych Services Clinic
918	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - TESTING	3550 6000	Psych Services Clinic

RC	RC Description	Dept	Description
919	PSYCHIATRIC/PSYCHOLOGICAL SERVICES - OTHER	3550 6000	Psych Services Clinic
920	OTHER DIAGNOSTIC SERVICES-GENERAL CLASSIFICATION		
921	OTHER DIAGNOSTIC SERVICES-PERIPHERAL VASCULAR LAB	3630 4100	Ultra Sound Radiology-Diagnostic
922	OTHER DIAGNOSTIC SERVICES - ELECTROMYELO-GRAM	3290	Electromyography
923	OTHER DIAGNOSTIC SERVICES - PAP SMEAR	3420 4400	Lab - Pathalogical Laboratory
924	OTHER DIAGNOSTIC SERVICES-ALLERGY TEST	6000	Clinic
925	OTHER DIAGNOSITC SERVICES-PREGNANCY TEST	3390 4400	Lab - Clinic Laboratory
929	OTHER DIAGNOSTIC SERVICES - OTHER		
940	OTHER THERAPEUTIC SERVICES-GENERAL CLASSIFICATION		
941	OTHER THERAPEUTIC SERVICES-RECREATIONAL THERAPY	3580 5100 6000	Recreational Therapy Occupatiional Therapy Clinic
942	OTHER THERAPEUTIC SERVICES-EDUCATION/ TRAINING (INCLUDES DIABETES RELATED DIETARY THERAPY)	6000 6100	Clinic Emergency
943	OTHER THERAPEUTIC SERVICES-CARDIAC REHABILITATION	3140 6000	Cardiology Clinic
944	OTHER THERAPEUTIC SERVICES-DRUG REHABILITATION	3550 6000	Psych Services Clinic
945	OTHER THERAPEUTIC SERVICES-ALCOHOL REHABILITATION	3550 6000	Psych Services Clinic
946	OTHER THERAPEUTIC SERVICES-ROUTINE COM-PLEX MEDICAL EQUIPMENT	EXCL	
947	ANCILLARY COMPLEX MEDICAL EQUIPMENT	EXCL	
949	OTHER THERAPEUTIC SERVICES-OTHER		
960	PROFESSIONAL FEES-GENERAL CLASSIFICATION	EXCL	
961	PROFESSIONAL FEES-PSYCHIATRIC	EXCL	
962	PROFESSIONAL FEES-OPTHALMOLOGY	EXCL	
963	PROFESSIONAL FEES-ANESTHESIOLOGIST (MD)	EXCL	
964	PROFESSIONAL FEES-ANESTHESTIST (CRNA)	EXCL	
969	PROFESSIONAL FEES-OTHER	EXCL	
971	PROFESSIONAL FEES-LABORATORY	EXCL	
972	PROFESSIONAL FEES-RADIOLOGY-DIAGNOSTIC	EXCL	
973	PROFESSIONAL FEES-RADIOLOGY-THERAPEUTIC	EXCL	
974	PROFESSIONAL FEES-NUCLEAR MEDICINE	EXCL	
975	PROFESSIONAL FEES-OPERATING ROOM	EXCL	
976	PROFESSIONAL FEES-RESPIRATORY THERAPY	EXCL	
977	PROFESSIONAL FEES-PHYSICAL THERAPY	EXCL	

RC	RC Description	Dept	Description
978	PROFESSIONAL FEES-OCCUPATIONAL THERAPY	EXCL	
979	PROFESSIONAL FEES-SPEECH PATHOLOGY	EXCL	
981	PROFESSIONAL FEES-EMERGENCY ROOM	EXCL	
982	PROFESSIONAL FEES-OUTPATIENT SERVICES	EXCL	
983	PROFESSIONAL FEES-CLINIC	EXCL	
984	PROFESSIONAL FEES-MEDICAL SOCIAL SERVICES	EXCL	
985	PROFESSIONAL FEES-EKG	EXCL	
986	PROFESSIONAL FEES-EEG	EXCL	
987	PROFESSIONAL FEES-HOSPITAL VISIT	EXCL	
988	PROFESSIONAL FEES-CONSULTATION	EXCL	
989	PROFESSIONAL FEES-PRIVATE DUTY NURSE	EXCL	
990	PATIENT CONVENIENCE ITEMS-GENERAL CLASSIFICATION	EXCL	
991	PATIENT CONVENIENCE ITEMS-CAFETERIA/ GUEST TRAY	EXCL	
992	PATIENT CONVENIENCE ITEMS-PRIVATE LINEN SERVICE	EXCL	
993	PATIENT CONVENIENCE ITEMS-TELEPHONE/ TELEGRAPH	EXCL	
994	PATIENT CONVENIENCE ITEMS-TV/RADIO	EXCL	
995	PATIENT CONVENIENCE ITEMS-NONPATIENT ROOM RENTALS	EXCL	
996	PATIENT CONVENIENCE ITEMS-LATE DISCHARGE CHARGE	EXCL	
997	PATIENT CONVENIENCE ITEMS-ADMISSION KITS	EXCL	
998	PATIENT CONVENIENCE ITEMS-BEAUTY SHOP/ BARBER	EXCL	
999	PATIENT CONVENIENCE ITEMS-OTHER	EXCL	

APPENDIX H

Interventional Radiology Logic

The codes listed in Appendix H are not assigned to an APG if any other code in the same APG is present on the claim. CPT-4 code descriptions are copyright American Medical Association.

APG	CODE	CODE DESCRIPTION
052	49400	INJECTION OF AIR OR CONTRAST INTO PERITONEAL CAVITY (SEPARATE PROCEDURE)
052	49427	INJECTION PROCEDURE (EG, CONTRAST MEDIA) FOR EVALUATION OF PREVIOUSLY PLACED PERITONEAL-VENOUS SHUNT
054	31708	INSTILLATION OF CONTRAST MATERIAL FOR LARYNGOGRAPHY OR BRONCHOGRAPHY, WITHOUT CATHETERIZATION
055	31710	CATHETERIZATION FOR BRONCHOGRAPHY, WITH OR WITHOUT INSTILLATION OF CONTRAST MATERIAL
055	31715	TRANSTRACHEAL INJECTION FOR BRONCHOGRAPHY
134	50392	INTRODUCTION OF INTRACATHETER OR CATHETER INTO RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS
134	50393	INTRODUCTION OF URETERAL CATHETER OR STENT INTO URETER THROUGH RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS
134	74475	INTRODUCTION OF INTRACATHETER OR CATHETER INTO RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS, RADIOLOGICAL SUPERVISION AND INTERPRETATION
134	74476	INTRODUCTION OF INTRACATHETER OR CATHETER INTO RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS, WITH FLUOROSCOPIC MONITORING ANDRADIOGRAPHY; COMPLETE PROCEDURE
134	74480	INTRODUCTION OF URETERAL CATHETER OR STENT INTO URETER THROUGH RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS, RADIOLOGICAL SUPERVISION AND INTERPRETATION
134	74481	INTRODUCTION OF URETERAL CATHETER OR STENT INTO URETER THROUGH RENAL PELVIS FOR DRAINAGE AND/OR INJECTION, PERCUTANEOUS, WITH FLUOROSCOPIC MONITORING AND RADIOGRAPHY; COMPLETE PROCEDURE
253	36010	INTRODUCTION OF CATHETER, SUPERIOR OR INFERIOR VENA CAVA
253	36011	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; FIRST ORDER BRANCH (EG, RENAL VEIN, JUGULAR VEIN)
253	36012	SELECTIVE CATHETER PLACEMENT, VENOUS SYSTEM; SECOND ORDER, OR MORE SELECTIVE, BRANCH (EG, LEFT ADRENAL VEIN, PETROSAL SINUS)
253	36013	INTRODUCTION OF CATHETER, RIGHT HEART OR MAIN PULMONARY ARTERY
253	36014	SELECTIVE CATHETER PLACEMENT, LEFT OR RIGHT PULMONARY ARTERY
253	36015	SELECTIVE CATHETER PLACEMENT, SEGMENTAL OR SUBSEGMENTAL PULMONARY ARTERY
253	36100	INTRODUCTION OF NEEDLE OR INTRACATHETER, CAROTID OR VERTEBRAL ARTERY
253	36101	INTRODUCTION OF NEEDLE OR INTRACATHETER, CAROTID OR VERTEBRAL ARTERY BILATERAL
253	36120	INTRODUCTION OF NEEDLE OR INTRACATHETER; RETROGRADE BRACHIAL ARTERY
253	36140	INTRODUCTION OF NEEDLE OR INTRACATHETER; EXTREMITY ARTERY
253	36160	INTRODUCTION OF NEEDLE OR INTRACATHETER, AORTIC, TRANSLUMBAR
253	36200	INTRODUCTION OF CATHETER, AORTA

APG	CODE	CODE DESCRIPTION
253	36215	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY
253	36216	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY
253	36217	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY
253	36218	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL SECOND ORDER, THIRD ORDER, AND BEYOND, THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY (USE IN ADDITION TO 36216 OR 36217 AS APPROPRIATE)
253	36230	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; SELECTIVE CATHETER PLACEMENT, CORONARY ARTERY, SINGLE OR MULTIPLE
253	36245	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY
253	36246	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY
253	36247	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY
253	36248	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL SECOND ORDER, THIRD ORDER, AND BEYOND, ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY (USE IN ADDITION TO 36246 OR 36247 AS APPROPRIATE)
253	36481	PERCUTANEOUS PORTAL VEIN CATHETERIZATION BY ANY METHOD
253	38200	INJECTION PROCEDURE FOR SPLENOPORTOGRAPHY
253	38791	INJECTION PROCEDURE FOR LYMPHANGIOGRAPHY BILATERAL
254	62284	INJECTION PROCEDURE FOR MYELOGRAPHY AND/OR COMPUTERIZED AXIAL TOMOGRAPHY, SPINAL (OTHER THAN C1-C2 AND POSTERIOR FOSSA)
254	62290	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL; LUMBAR
254	62291	INJECTION PROCEDURE FOR DISKOGRAPHY, EACH LEVEL; CERVICAL
255	19030	INJECTION PROCEDURE ONLY FOR MAMMARY DUCTOGRAM OR GALACTOGRAM
255	20501	INJECTION OF SINUS TRACT; DIAGNOSTIC (SINOGRAM)
255	21116	INJECTION PROCEDURE FOR TEMPOROMANDIBULAR JOINT ARTHROGRAPHY
255	23350	INJECTION PROCEDURE FOR SHOULDER ARTHROGRAPHY
255	24220	INJECTION PROCEDURE FOR ELBOW ARTHROGRAPHY
255	25246	INJECTION PROCEDURE FOR WRIST ARTHROGRAPHY
255	27093	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITHOUT ANESTHESIA
255	27095	INJECTION PROCEDURE FOR HIP ARTHROGRAPHY; WITH ANESTHESIA
255	27370	INJECTION PROCEDURE FOR KNEE ARTHROGRAPHY

APG	CODE	CODE DESCRIPTION
255	27648	INJECTION PROCEDURE FOR ANKLE ARTHROGRAPHY
255	36005	INJECTION PROCEDURE FOR CONTRAST VENOGRAPHY (INCLUDING INTRODUCTION OF NEEDLE OR INTRACATHETER)
255	38790	INJECTION PROCEDURE FOR LYMPHANGIOGRAPHY
255	42550	INJECTION PROCEDURE FOR SIALOGRAPHY
255	45355	COLONOSCOPY, RIGID OR FLEXIBLE, TRANSABDOMINAL VIA COLOTOMY, SINGLE OR MULTIPLE
255	47500	INJECTION PROCEDURE FOR PERCUTANEOUS TRANSHEPATIC CHOLANGIOGRAPHY
255	50394	INJECTION PROCEDURE FOR PYELOGRAPHY (AS NEPHROSTOGRAM, PYELOSTOGRAM, ANTEGRADE PYELOURETEROGRAMS) THROUGH NEPHROSTOMY OR PYELOSTOMY TUBE, OR INDWELLING URETERAL CATHETER
255	50684	INJECTION PROCEDURE FOR URETEROGRAPHY OR URETEROPYELOGRAPHY THROUGH URETEROSTOMY OR INDWELLING URETERAL CATHETER
255	50690	INJECTION PROCEDURE FOR VISUALIZATION OF ILEAL CONDUIT AND/OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE
255	51600	INJECTION PROCEDURE FOR CYSTOGRAPHY OR VOIDING URETHROCYSTOGRAPHY
255	51605	INJECTION PROCEDURE AND PLACEMENT OF CHAIN FOR CONTRAST AND/OR CHAIN URETHROCYSTOGRAPHY
255	51610	INJECTION PROCEDURE FOR RETROGRADE URETHROCYSTOGRAPHY
255	54230	INJECTION PROCEDURE FOR CORPORA CAVERNOSOGRAPHY
255	58340	INJECTION PROCEDURE FOR HYSTEROSALPINGOGRAPHY
255	58345	TRANSCERVICAL INTRODUCTION OF FALLOPIAN TUBE CATHETER FOR DIAGNOSIS AND/OR RE-ESTABLISHING PATENCY (ANY METHOD), WITH OR WITHOUT HYSTEROSALPINGOGRAPHY
255	61070	PUNCTURE OF SHUNT TUBING OR RESERVOIR FOR ASPIRATION OR INJECTION PROCEDURE
255	68850	INJECTION OF CONTRAST MEDIUM FOR DACRYOCYSTOGRAPHY

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APPENDIX I

List of Outside Evaluators

FAMILY PRACTICE AND INTERNAL MEDICINE

Robert Berenson, MD
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Oliver Fein, MD
Director - Adult Internal Medicine, Presbyterian Hospital, New York, NY

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Robert Master, MD
Section Chief, Health Services Research, Boston University School of Medicine, Boston MA

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David Nash, MD
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Associate Professor, Division of Adolescent Medicine, University of Southern California School of Medicine, Los Angeles, CA

NOTE: Many professionals were consulted in more than one area.

APPENDIX J

Description of APG Modifications in Version 2.0

DETAILED APG CHANGES - BY APG

[] New V2 APG number

APG 1 [1] Photochemotherapy

No change in APG definition or code composition.

APG 2 [2] Superficial Needle Biopsy and Aspiration

No substantive change in APG definition; one code was moved out to APG 135, Deep Lymph Structure and Thyroid Procedures.

Several aspiration codes and biopsy codes were moved from other APGs into this APG. (e.g., 48102, Needle biopsy of pancreas from APG 159 and 55000, Puncture aspiration of hydrocele from APG 209).

APG 3 [4] Simple Incision and Drainage

No substantive change in APG definition; two codes were transferred to the Complex Incision and Drainage APG and one code was moved to APG 5 Nail Procedures.

Code 36425, Venipuncture cutdown, one year or over, was moved into this APG from APG 109, Placement of Transvenous Catheters. The other procedures in APG 109 were much more complex than the procedure described in code 36425.

APG 4 [3] Complex Incision and Drainage

No change in APG definition, some changes in code composition. No codes were moved out of this APG, however, codes were moved into this APG for several reasons. Several codes were moved from Simple Incision and Drainage because they were felt to be too complex to stay in the simple incision group (e.g., code 28001, Incision and drainage infected bursa, foot). Several codes were moved from an APG in the musculoskeletal system as they were felt to be more appropriately placed within the integumentary system (e.g., 27301, Incision and drainage of deep abscess).

APG 5 [5] Nail Procedures

No substantive change to this APG; no codes were moved out, one code was moved into this APG. Code 11740, Evacuation of subungual hematoma, was moved from APG 3, Simple Incision and Drainage, because this procedure was anatomically more similar to procedures in APG 5; it also consumed similar resources.

APG 6 [6] Simple Debridement and Destruction

No change in APG definition, some changes in code composition; two codes were transferred to the complex excision, debridement and biopsy APG, two

dressing codes and two other minor procedure codes were moved to ancillary procedure APGs 384 and 385.

Two types of codes were moved into this APG. Several codes were moved from APG 8 because it was difficult to distinguish them from other codes already in APG 6. Thus, code 11040, Debridement, skin, partial thickness, is difficult to distinguish from code 11041, Debridement, skin, full thickness. Other codes were moved into APG 6 from specialty based areas such as ENT because they consumed smaller amounts of resources than other codes within those specialty APGs. Thus, code 42809, Removal of foreign body in pharynx, was moved to this APG from an ENT APG because the other codes in the simple ENT APG consume more resources.

APG 7 [8] Simple Excision and Biopsy

No change in APG definition, some changes in code composition. One code was transferred to the complex excision APG, two codes were moved to APG 135, Deep Lymph Structure and Thyroid Procedures.

Several biopsy codes were moved from specialty based APGs to APG 7. Thus, for reasons of differences in resource consumption, code 68100, Biopsy of conjunctiva, was moved from an opthalmological APG to APG 7. Procedures in APG 7 consume fewer resources than procedures in the least resource intensive ophthalmological APG.

APG 8 [7] Complex Excision, Biopsy and Debridement

No change in APG definition, some changes in code composition. Four codes were transferred to the simple excision and biopsy APG, one code was moved to the new APG 24, Simple Hand and Foot Musculoskeletal Procedures.

Several codes were moved from this APG to the simple excision and biopsy APG because it was difficult to distinguish them from other codes already in the simple excision APG. Thus, code 20240, Biopsy, excisional, superficial, was moved from APG 7 as it was thought to be difficult to distinguish from code 20245, Excisional biopsy, deep.

APG 9 [X] Lipectomy and Excision with Reconstruction

This APG was deleted; all codes were moved to APG 11, the complex skin repairs APG.

APG 10 [10] Simple Skin Repair

No change in APG definition; several codes referring to length of repairs were moved from the complex skin repair APG to the simple skin repairs APG. Thus, code 12044, Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 to 12.5 cm) was moved from APG 11 to this APG.

APG 11 [9] Complex Skin Repairs Incl Integument Grafts, Transfer & Rearrange

Significant change in APG definition and composition. APG definition expanded to include integument grafts, transfers and rearrangements. A third of the original codes were moved to the simple repair APG; all codes previously in APGs 9 and 12 were moved to this APG. Thus, three APGs: Lipectomy and Excision with Reconstruction; Complex Skin Repair and Skin and Integument Graft, Transfer and Rearrangement were combined to form one Complex Skin Repairs APG. This was done for similarity in resource consumption between the APGs. In addition, only a small number of cases were recorded in, for example, the Integument Graft APG.

APG 12 [X] Skin and Integument Graft, Transfer and Rearrangement

This APG was deleted, all codes were moved to APG 11.

APG 27 [11] Simple Incision and Excision of Breast

No substantive change to this APG, one code was moved to the complex incision and drainage APG.

APG 28 [12] Breast Reconstruction and Mastectomy

There was no change to this APG.

APGs 21-24 [NEW] Simple/Complex Musculoskeletal Procedures

Codes were moved into these APGs for several reasons. Most importantly, numerous codes were taken from other APGs in this body system to form these APGs. Thus, codes referring to musculoskeletal procedures excluding hand and foot which consume significant resources were taken from APGs entitled: Incision of Bone, Joint and Tendon; Excision of bone, joint and tendon except hand and foot; Complex hand and foot repair; Repair, except arthrotomy of bone, joint, tendon except of hand and foot; Arthrotomy except of hand and foot. Several APGs were thus amalgamed into four new APGs (Complex and Simple Musculoskeletal Procedures of Hand and Foot and Complex and Simple Musculoskeletal Procedures Excluding Hand and Foot.) This resulted in a smaller number of groups which were more uniform in resource consumption.

Several codes, such as 27889 (Ankle disarticulation), were moved from APG 995, Inpatient procedures, because it can be occasionally performed on an outpatient basis.

APG 53 [271] Occupational Therapy

There was no change to this APG.

APG 54 [272] Physical Therapy

There was no change to this APG.

APG 55 [X]: Diagnostic Arthroscopy

This APG was deleted; all codes were moved to APG 56.

APG 56 [25]: Arthroscopy

The diagnostic and therapeutic arthroscopy APGs were combined together to form one arthroscopy APG. There often was not a clear cut clinical distinction between many of the codes. In addition, there was little difference in resource consumption between the two APGs.

APG 57 [26] Replacement of Cast

There was no change to this APG.

APG 58 [27] Splint, Strapping and Cast Removal

There was minimal change to this APG; one code was moved out.

APG 59 [28] Closed Treatment of Fx and Dislocation of Finger, Toe and Trunk

This APG was redefined to include fracture and dislocation of the trunk; three codes were moved to APG 63, Bone or joint manipulation under anesthesia. All the codes moved into this APG, such as 27200, Coccygeal fracture, refer to fractures that are not casted.

APG 60 [29] Closed Treatment of Fx and Dislocation, Except Finger, Toe and Trunk

This APG was redefined; a full 30 percent of the codes were moved to other APGs. Several codes for trunk area fractures were moved to APG 59; several codes for percutaneous treatment of fractures were moved to APG 62 and codes for manipulation under anesthesia were moved to APG 63. The few codes that were moved into this APG, such as 25675, Closed treatment of radioulnar dislocation, were transferred for reasons of misplacement.

APG 62 [30] Open or Percutaneous Treatment of Fractures

This APG was significantly reformulated. Previously, this APG contained open reduction of fractures. Now, this APG contains both open and percutaneous reduction of fractures. Percutaneous reduction of fractures consumes similar amounts of resources to open reduction of fractures and many more resources than otherwise closed reduction of fractures.

APG 63 [31] Bone or Joint Manipulation Under Anesthesia

No codes were moved out of this APG. Several bone and joint manipulation procedures performed under general anesthesia, such as 23655, Closed treatment of shoulder dislocation with manipulation, requiring anesthesia, were moved into this APG.

APG 64 [X] Simple Maxillofacial Procedures

This APG was deleted. Most of the codes were moved to the new APG for simple facial & ENT procedures. A few codes were moved to the complex maxillofacial procedures APG and a few to the inpatient procedures (error) APG.

APG 65 [X] Complex Maxillofacial Procedures

This APG was deleted. Most of the codes were moved to the new APG for complex maxillofacial and ENT procedures; a few codes were moved to the simple maxillofacial and ENT procedures APG and several other codes to the inpatient procedures (error) APG.

APG 66 [X] Incision of Bone, Joint and Tendon

This APG was deleted. Most of the codes (97 percent) were distributed among four new APGs for simple and complex musculoskeletal procedures. A few remaining codes were moved to the complex incision and drainage APG in the integumentary system.

APG 67 [32] Bunion procedures

There was no change to this APG.

APG 68 [X] Excision of Bone, Joint and Tendon of Hand and Foot

This APG was deleted. All the codes were distributed among three APGs for simple and complex musculoskeletal procedures.

APG 69 [X] Excision of Bone, Joint and Tendon Except Hand and Foot

This APG was deleted. All the codes were distributed among three APGs for simple and complex musculoskeletal procedures.

APG 70 [33] Arthroplasty

There was no change to this APG.

APG 71 [34] Hand and Foot Tenotomy

There was no change to this APG.

APG 72 [X] Simple Hand and Foot Repair

This APG was deleted. The codes were distributed between the simple and the complex hand and foot musculoskeletal procedure APGs.

APG 73 [X] Complex Hand and Foot Repair

This APG was deleted. Most of the codes (97 percent) were moved to the complex hand and foot musculoskeletal procedures APG; a few remaining codes went to other musculoskeletal APGs.

APG 74 [X] Repair, Except Arthrotomy, of Bone, Joint, Tendon Except Hand & Foot

This APG was deleted. All the codes were distributed among the simple and complex musculoskeletal procedure APGs.

APG 75 [X] Arthrotomy Except Hand and Foot

This APG was deleted. All codes were moved to the complex musculoskeletal procedures APG.

APG 76 [35] Arthrocentesis and Ligament or Tendon Injection

There was no change to this APG.

APG 77 [273] Speech Therapy

There was no change to this APG.

APG 79 [51] Pulmonary Test and Therapy Except Spirometry

This APG was redefined to exclude therapy codes. All the therapy codes from this APG (30 percent of the total) were moved to a new Respiratory Therapy APG.

APG 80 [52] Needle and Catheter Biopsy, Aspiration, Lavage and Intubation

There was significant change to this APG. Several codes (20 percent of the total) were moved to the superficial needle biopsy APG; several endoscopy codes (another 20 percent of the total) were moved to APGs for endoscopy of the upper airway and the lower airway. Several needle and catheter type procedures, such as code 33010, Pericardiocentesis, were moved into this APG. Thus this APG is not exclusively pulmonary needle and catheter procedures.

APG 81 [54] Simple Endoscopy of the Upper Airway

No significant change to this APG; one code was moved to the incidental APG. The small number of codes which were moved into this APG, such as code 31577, Laryngoscopy, flexible fiberoptic; diagnostic with removal of foreign body, were transferred from other airway endoscopy APGs for reasons of similarity in resource consumption to other codes in APG 81.

APG 82 [53] Complex Endoscopy of the Upper Airway

No significant change to this APG; one code was moved to the simple endoscopy APG.

APG 83 [X] Simple Endoscopy of the Lower Airway

This APG was deleted; all codes were moved to APG 84.

APG 84 [55] Complex Endoscopy of the Lower Airway

This APG was redefined; two APGs, simple and complex endoscopy of the lower airway, were combined to form this APG as it was difficult to distinguish differences in resource consumption between these two groups.

APG 85 [233] Nasal Cauterization and Packing

One code, 42960, Control of oropharyngeal hemorrhage, was moved from an ENT APG to the nasal cauterization and packing APG as all the other codes in the latter APG pertain to control of nasal hemorrhage.

APG 86 [X] Simple Lip, Mouth and Salivary Gland Procedures

This APG was deleted; more than 90 percent of the codes were moved to the new simple facial and ENT procedures APG; a few codes were moved to the complex facial and ENT procedure APG.

APG 87 [X] Complex Lip, Mouth and Salivary Gland Procedures

This APG was deleted; a majority (85 percent) of the codes were moved to the new complex facial and ENT procedures APG; several codes were moved to the simple facial and ENT procedures APG.

APG 88 [X] Miscellaneous Sinus, Tracheal and Lung Procedures

This APG was deleted; a majority of the codes were distributed between the simple and the complex facial and ENT procedure APGs. Two lung and pleural procedure codes were moved to an APG in the respiratory system.

APG 105 [71] Exercise Tolerance Tests

There was no change to this APG.

APG 106 [72] Echocardiography

There was no change to this APG.

APG 107 [73] Phonocardiogram

Minimal change, one code, 93210, Phonocardiogram, intracardiac, was moved into this phonocardiogram APG.

APG 108 [74] Cardiac Electrophysiologic tests

No change in APG definition; two codes were moved to the Resuscitation and Cardioversion APG.

APG 109 [75] Placement of Transvenous Catheters

There was significant change in the code composition of this APG; approximately 50 percent of the codes were assigned to other APGs. For example, two codes (36860 and 36861) were moved to the minor vascular repair APG; one code (36420) was moved to the simple incision and drainage APG and three codes (36620, 36625 and 36640) were moved to the Ancillary APG for vascular radiology. One code, 36500, Venous catheterization, was moved to this APG as all other codes pertain to some form of venous catheterization.

APG 110 [76] Diagnostic Cardiac Catheterization

This APG remained essentially unchanged, one code was moved to the phonocardiogram APG.

APG 111 [77] Angioplasty and Transcatheter Procedures

Several codes were moved out of this APG; three codes were reassigned to the inpatient procedures APG, one code to another cardiovascular APG and one to an Ancillary APG. Only one code, 35454, Transluminal balloon angioplasty, open, iliac, was moved to this APG. This procedure can be occasionally performed on an outpatient basis.

APG 112 [78] Pacemaker Insertion and Replacement

There was minimal change to this APG; one code was moved into this APG.

APG 113 [79] Removal and Revision of Pacemaker and Vascular Device

There was minimal change to this APG; one code was moved into this APG.

APG 114 [80] Minor Vascular Repair and Fistula Construction

Two codes, 36860 and 36861, Cannula declotting with and without balloon catheters, were moved to this APG from the vascular cannulation APG (109) as these procedures are more complex than those in APG 109.

APG 115 [81] Secondary Varicose Veins and Vascular Injection

There was no change to this APG.

APG 116 [82] Vascular Ligation

There was no change to this APG.

APG 117 [83] Resuscitation and Cardioversion

Two codes, 92953, Temporary transcutaneous pacing and 92960, Elective cardioversion, were moved to the resuscitative cardioversion APG as these procedures occur in the resuscitative process.

APG 131 [91] Chemotherapy by Extended Infusion

There was no change to this APG.

APG 132 [92] Chemotherapy Except by Extended Infusion

One code, 51720, Bladder instillation of anticarcinogenic agent, was moved from a urologic APG to this APG as the code pertains to instillation of material for the treatment of cancer.

APG 133 [93] Phlebotomy

This APG was divided into two APGs; the transfusion codes were moved to a new, separate APG for transfusions, the code for phlebotomy remained.

APG 134 [94] Blood and Blood Product Exchange

There was no change to this APG.

APG 135 [95] Deep Lymph Structure and Thyroid Procedures

There was no change in definition of this APG; one code was moved out to the complex facial and ENT procedures APG. Two reasons account for the small number of codes that were moved into this APG. One code, 60220, Total thyroid lobectomy, was moved from the inpatient only APG to this APG as it can occasionally be performed on an outpatient basis. Other codes moved into this APG were moved for reasons of similarity in resource consumption to other codes in this APG. Thus, 38500, (Biopsy of lymph node, superficial, is similar in resource consumption to 38510, Biopsy of lymph node, cervical deep.

APG 136 [96] Allergy Tests

This APG remained essentially unchanged; two codes were moved to the medical visit indicator APG.

APG 157 [111] Alimentary Tests and Simple Tube Placement

No codes were moved out of this APG; several gastrointestinal aspiration codes were moved from simple and complex pathology as they are similar to the other tube placement codes in this APG.

APG 158 [112] Esophageal Dilation without Endoscopy

There was no change to this APG.

159 [X] Percutaneous and Other Simple Gastrointestinal Biopsy

This APG was deleted; the codes were divided between two APGs, Superficial needle biopsy and aspiration and Diagnostic upper GI endoscopy or intubation.

APG 160 [113] Anoscopy with Biopsy and Diagnostic Proctosigmoidoscopy

This APG remained essentially unchanged; one code, 46999, Unlisted procedure, anus, was moved to this APG.

APG 161 [114] Proctosigmoidoscopy with Excision or Biopsy

There was no change to this APG.

APG 162 [115] Diagnostic Upper Gastrointestinal Endoscopy

There was no change in the definition of this APG; one code was moved to the therapeutic upper GI endoscopy APG and several codes pertaining to gastrointestinal intubation, a form of endoscopy, were moved from the now defunct percutaneous and other simple gastrointestinal biopsy APG.

APG 163 [116] Therapeutic Upper Gastrointestinal Endoscopy

A number of codes were transferred to this APG from the miscellaneous digestive procedures APG that was eliminated. This was done as many of the procedures were not too dissimilar from other procedures in this APG. Thus, code 43750, Small intestinal endoscopy, was not too dissimilar in terms of resource consumption and clinical complexity from other therapeutic upper GI endoscopy codes in this APG.

164 [X] Diagnostic Lower Gastrointestinal Endoscopy

This APG was deleted; all codes were moved to APG 165.

APG 165 [117] Lower GI Endoscopy

This APG was redefined; it contains the codes from two APGs: Therapeutic and Diagnostic Lower GI Endoscopy. There often was not a clear cut clinical distinction between many of the codes. In addition, there was little difference in resource consumption between the two APGs.

APG 166 [118] ERCP and Miscellaneous Gastrointestinal Endoscopy Procedures

Several codes were moved from this APG to the upper GI endoscopy APGs; many codes were transferred to this APG from the now eliminated Miscellaneous Digestive Procedure APG. Many of the codes in this now eliminated APG represented a complicated form of endoscopy. ERCPs are a complicated form of endoscopy.

APG 167 [236] Tonsil and Adenoid Procedures

There was no change to this APG.

APG 168 [119] Hernia and Hydrocele Procedures

There was no change to this APG.

APG 169 [X] Simple Hemorrhoid Procedures

This APG was deleted; the codes were moved to APG 170, Simple anal and rectal procedures.

APG 170 [121] Simple Anal and Rectal Procedures

A few codes were moved from this APG to the complex anal and rectal procedures APG, then two APGs were combined: Simple Hemorrhoid Procedures and Simple Anal and Rectal Procedures Except Hemorrhoid Procedures. The two APGs were combined as they are similar with respect to resource consumption and clinical complexity.

APG 171 [120] Complex Anal and Rectal Procedures

For reasons of complexity and resource consumption, three codes, such as surgical treatment of anal fistula, subcutaneous, were moved from the simple anal procedure APG to the complex.

APG 172 [X] Peritoneal Procedures and Change of Intra-Abdominal Tube

This APG was deleted; the codes were divided between the needle and catheter biopsy APG and the tube change APG.

APG 173 [122] Miscellaneous Abdominal Procedures

Several codes were moved out of this APG to other, more specific APGs for Digestive procedures. One code was moved to the Ancillary tube change APG. No codes were shifted into this APG.

APG 123 [NEW] Complex Laparoscopic Procedures

This is one of two new APGs pertaining to laparoscopy. All of the codes in this APG, such as 56340, Laparoscopic cholecystectomy, are complex in terms of time required and resource consumption.

APG 124 [NEW] Simple Laparoscopic Procedures

This is a new APG and consists of simple laparoscopic procedures, such as code 56300, Laparoscopy, diagnostic.

APG 183 [132] Simple Urinary Studies and Procedures

A few codes from this APG were reassigned; for example, two codes were moved to an ancillary procedures APG and two to the APG for services incidental to medical, significant procedure or therapy visits.

APG 184 [131] Renal Extracorporeal Shock Wave Lithotripsy

One code, 52337, was moved into this APG as it included lithotripsy.

APG 185 [133] Urinary Catheterization and Dilatation

One code, 51700, Bladder irrigation, simple, was moved into this APG as the procedure involved bladder catherization.

APG 186 [139] Hemodialysis

There was no change to this APG.

APG 187 [140] Peritoneal Dialysis

There was no change to this APG.

APG 188 [135] Moderate Cystourethroscopy

This APG was completely redefined and its code composition reformulated. A third APG was added to the two already existing cystourethroscopy APGs; thus, there are now simple, moderate and complex urethroscopic APGs. Several codes were moved from this moderate cystourethroscopy APG to the newly created simple cystourethroscopy APG and codes for cystourethroscopic procedures that were of moderate complexity were moved to this APG from other APGs in the male system.

Several APGs, such as APG 190 Cystotomy, were eliminated. One of the codes from that APG, 51040, cystostomy, cystotomy with drainage, was placed into this APG as it was one of the simpler cystotomy procedures which could be performed on an outpatient basis.

APG 189 [134] Complex Cystourethroscopy and Litholapexy

Three APGs were eliminated and most of the codes were placed into the complex cystourethroscopy APG. These APGs, Percutaneous Renal Endoscopy; Cystotomy; and Transurethral Resection of Prostate, were all extremely complex and thus infrequently performed on an outpatient basis. The procedures which were performed on an outpatient basis, while still complex, represented the simpler forms of, for example, transurethral resection of prostate.

APG 190 [X] Percutaneous Renal Endoscopy, Catheterization & Ureteral Endoscopy

This APG was deleted; all except two of the codes were moved to the new complex cystourethroscopy APG. Two codes were moved to the superficial needle biopsy and aspiration APG.

APG 191 [X] Cystotomy

This APG was deleted; a majority of the codes were moved to the new complex cystourethroscopy APG, one code was moved to the moderate cystourethroscopy APG.

APG 192 [138] Simple Urethral Procedures

There was no change in APG definition or description. Two codes, both excision of urethral diverticulitis, were moved, for reasons of complexity from the complex to the simple urethral procedures APG.

APG 193 [137] Complex Urethral Procedures

There was no change in APG definition and minimal code movement into or out of this APG. One code, 52500, Transurethral resection of bladder neck, from the prostate procedures APG was placed in this APG as it did not involve a cystourethroscopy.

APG 209 [151] Testicular and Epididymal Procedures

There was no change in the definition of this APG. Two codes were moved to the superficial needle biopsy and aspiration APG.

APG 210 [152] Insertion of Penile Prosthesis

There was no change in the definition of this APG. Two codes were moved into this APG as they involved the use of a penile prosthesis, a very expensive resource.

APG 211 [153] Complex Penile Procedures

There was no change in the definition of this APG. One code, 54220, Irrigation of corpora cavernosa for priapism, was moved to this APG from the simple penile procedure APG as the procedure involves significant effort.

APG 212 [154] Simple Penile Procedures

There was no change in the definition of this APG. Two codes were moved to the minor reproductive procedures APG and one, as noted above, to the complex penile procedures APG.

APG 213 [155] Prostate Needle and Punch Biopsy

There was no change to this APG.

APG 214 [X] Transurethral Resection of Prostate & Other Prostate Procedures

This APG was deleted; the codes were divided between the moderate and the complex cystourethroscopy APGs.

APG 235 [171] Artificial Fertilization

There was no change in the definition of this APG. One code, 58970, Follicle puncture for oocyte retrieval, any method, was moved into this APG as the purpose of the procedure is for artificial fertilization.

APG 236 [172] Procedures for Pregnancy and Neonatal Care

This APG remained essentially unchanged.

APG 237 [173] Treatment of Spontaneous Abortion

There was no change to this APG.

APG 238 [174] Therapeutic Abortion

There was no change to this APG.

APG 239 [175] Vaginal Delivery

There was no change to this APG.

APG 240 [X] Female Genital Endoscopy

This APG was deleted. Code 58970 was moved to the artificial fertilization APG.

APG 241 [180] Colposcopy

Two separate APGs were formed; one specifically for colposcopy procedures and the other for hysteroscopy procedures. One code was moved to the APG for simple female reproductive procedures.

APG 242 [177] Simple Female Reproductive Procedures

This APG was redefined to represent Simple, rather than the previous Miscellaneous Female Reproductive procedures. Several colposcopy codes, such as 57020, Colpocentesis, were put into this APG as they consume few resources and do not involve a colposcope. A few codes, such as 58800, Drainage of ovarian cyst, was moved from the complex female reproductive APG as it did not consume as much effort as the other codes in that APG.

APG 243 [178] Dilatation and Curettage

There was no change to this APG.

APG 244 [176] Complex Female Reproductive Procedures

This APG was redefined to represent complex female reproductive procedures instead of the former female genital excision and repair. Several codes were moved from this APG to the simple female reproductive procedures APG. No codes were moved into this APG.

APG 261 [192] Electroencephalogram

Several codes were moved from this APG to the new extended EEG studies APG.

APG 262 [193] Electroconvulsive Therapy

There was no change to this APG.

APG 263 [194] Nerve and Muscle Tests

Two codes from other body systems were moved into this APG. These codes, such as 92280, Visually evoked potential study, represent a nerve test.

APG 264 [X] Injection of Substance into Spinal Cord

This APG was deleted; all codes moved to APG 266, Nerve injection and stimulation.

APG 265 [X] Subdural and Subarachnoid Tap

This APG was deleted; all except one code was moved to APG 266, Nerve injection and stimulation. One code was moved to the miscellaneous radiological procedures APG.

APG 266 [195] Nervous System Injections, Stimulations or Cranial Tap

This APG was redefined to include spinal cord injections and cranial taps which had defined APGs 264 and 265 respectively; those APGs were combined with this APG. Also, simpler nerve injection/stimulation codes, such as 64555, Percutaneous implantation of neurostimulator electrodes, peripheral nerve, coming from APG 268, Neurostimulator and Ventricular Shunt Implantation, were put into this APG as they were much less complex than other codes in their respective APGs.

APG 267 [196] Revision and Removal of Neurological Device

There was minimal change to this APG. One code, 62230, Replacement or revision of csf shunt, obstructed valve, was put into this APG from the inpatient only APG, as revisions can occasionally be performed on an outpatient basis.

APG 268 [197] Neurostimulator and Ventricular Shunt Implantation

There was no change in the definition of this APG. Two codes were moved to the nervous system injection, stimulation or cranial tap APG.

APG 269 [X] Carpal Tunnel Release

This APG was deleted; its code content was moved to the nerve repair and destruction APG.

APG 270 [198] Nerve Repair and Destruction

This APG represents a combination of three APGs. All consisted of peripheral nerve reairs and all consume similar amounts of resources and are clinically similar.

APG 271 [X] Complex Nerve Repair

This APG was deleted; all its codes were moved to the nerve repair and destruction APG.

APG 272 [199] Spinal Tap

There was no change to this APG.

APG 287 [211] Minor Ophthalmological Tests and Procedures

There was no change in the definition of this APG. One code (92280) was moved to the nerve and muscle tests APG and one code (92065) to the ancillary APG for biofeedback and other training.

APG 288 [212] Fitting of Contact Lenses

There was minimal change to this APG. One code was moved to the APG for provision of vision aids.

APG 289 [X] Simple Laser Eye Procedures

This APG was deleted; all its codes were moved to APG 290.

APG 290 [213] Laser Eye Procedures

This APG was redefined; the simple and the complex laser eye procedure APGs were combined into this APG.

APG 291 [214] Cataract Procedures

There was no change to this APG.

APG 292 [217] Simple Anterior Segment Eye Procedures

This APG was redefined; all simple anterior segment eye procedures were placed into this APG regardless of the reason for the procedure.

APG 293 [X] Complex Anterior Segment Eye Procedures for Glaucoma

This APG was deleted. Three codes were placed into the simple anterior segment eye procedures APG, the others were placed into the moderate anterior segment eye procedures APG.

APG 294 [X] Simple Anterior Segment Procedures Except for Glaucoma

This APG was deleted. Half the codes were moved to the simple anterior segment eye procedures APG; the others were distributed among several APGs in the skin and integumentary system as well as other eye procedure APGs.

APG 295 [216] Moderate Anterior Segment Eye Procedures

There was considerable movement of codes into and out of this APG. Half of the original codes from this APG were redistributed among other eye procedure APGs. Several codes from the deleted complex anterior segment procedures for glaucoma were moved into this APG.

APG 296 [215] Complex Anterior Segment Eye Procedures

This APG was redefined to remove any distinction based on the reason for the procedure. Two codes were moved to other eye procedure APGs.

APG 297 [219] Simple Posterior Segment Eye Procedures

There was no change in the definition of this APG. Three codes were moved to the complex posterior segment eye procedures APG.

APG 298 [218] Complex Posterior Segment Eye Procedures

This APG was more specifically defined; all the vitrectomy procedure codes were moved out of this APG to a separate, new, vitrectomy APG.

APG 299 [220] Strabismus and Muscle Eye Procedures

There was minimal change to this APG; one code was moved to the simple excision and biopsy APG.

APG 300 [222] Simple Repair and Plastic Procedures of Eye

There was minimal change to this APG; one code was moved to the complex repair and plastic procedures of eye APG.

APG 301 [221] Complex Repair and Plastic Procedures of Eye

There was minimal change to this APG; one code was moved to the simple repair and plastic procedures of eye APG.

APG 313 [232] Otorhinolaryngologic Function Test

There was minimal change to this APG. One code, 92516, facial nerve function studies, was moved out to the nerve and muscle test APG and one code was moved to this APG from an ancillary APG.

APG 314 [X] Major External Ear Procedures

This APG was deleted; all the codes were moved to the new APG for complex facial and ENT procedures.

APG 315 [X] Tympanostomy and Other Simple Middle Ear Procedures

This APG was deleted. A majority of the codes were moved to the new APG for simple facial and ENT procedures. One code was moved to the simple debridement and destruction APG and another to the incidental services APG.

APG 316 [X] Tympanoplasty and Other Complex Middle Ear Procedures

This APG was deleted; all codes were moved to the new complex facial and ENT procedures APG.

APG 317 [X] Inner Ear Procedures

This APG was deleted. One code, 69930, Cochlear device implantation, with or without mastoidectomy, was moved to a new APG, Cochlear Device Implantation; all other codes were moved to the new complex facial and ENT procedures APG.

APG 318 [237] Simple Audiometry

There was no change to this APG.

APG 319 [X] Removal of Impacted Cerumen

This APG was deleted; the code was moved to APG 384, a new ancillary procedures APG.

ANCILLARY APGs

APG 341-360 [251-255, 301-311] Radiology APGs

The radiology APGs were restructured. Five APGs which consisted of therapeutic and other significant radiological procedures were changed from ancillary to significant procedure APGs.

APG 341 [303] Simple Diagnostic Nuclear Medicine

The definition of this APG was refined; several codes were moved to a new intermediate diagnostic nuclear medicine APG and a few codes to the complex nuclear medicine APG.

APG 342 [301] Complex Diagnostic Nuclear Medicine

The definition of this APG was refined; several codes were moved to a new intermediate diagnostic nuclear medicine APG and a few codes to the simple nuclear medicine APG.

APG 343 [251] Therapeutic Nuclear Medicine by Injection

There was no change in APG definition or composition. The APG type was changed from Ancillary to Significant Procedure.

APG 344 [252] Radiation Therapy

This APG was redefined to include hyperthermia procedures. The APG type was changed from Ancillary to Significant Procedure.

APG 345 [304] Obstetrical Ultrasound

There was no change to this APG.

APG 346 [305] Diagnostic Ultrasound Except Obstetrical

There was no change to this APG.

APG 347 [X] Hyperthermia

This APG was deleted; all codes were moved to the radiation therapy APG.

APG 348 [306] Magnetic Resonance Imaging

There was no change to this APG.

APG 349 [307] Computerized Axial Tomography

There was no change to this APG.

APG 350 [308] Mammography

There was no change to this APG.

APG 351 [310] Plain Film

There was minimal code movement out of this APG, no codes were moved in.

APG 352 [X] Fluoroscopy

This APG was deleted; the codes were redistributed among the plain film APG and several significant procedure APGs.

APG 353 [253] Cerebral, Pulmonary, Cervical and Spinal Angiography

Codes were moved into this APG from the introduction of needle and catheter APG and the ratiological supervision and interpretation APG. The APG title was changed to Vascular Radiography Except Venography of Extremity.

APG 354 [X] Venography of Extremity

This APG was deleted; all procedure codes previously in this APG were deleted.

APG 355 [X] Non-cardiac, Non-cerebral Vascular Radiology

This APG was deleted; the codes were redistributed among two new significant procedure radiology APGs and one transvenous catheter placement APG.

APG 356 [309] Digestive Radiology

One code was moved to the APG for miscellaneous radiological procedures with contrast.

APG 357 [X] Urography and Genital Radiology

This APG was deleted; all codes were moved to the significant procedure APG for miscellaneous radiological procedures with contrast.

APG 358 [X] Arthrography

This APG was deleted; all the CPT-4 codes which made up this APG have also been deleted.

APG 359 [254] Myelography

All the original CPT-4 codes from this APG have been deleted; several codes were moved into this APG from the introduction of needle and catheter APG and the former radiological supervision and interpretation APG. The myelography APG was changed from an ancillary APG to a significant procedure APG.

APG 360 [255] Miscellaneous Radiological Procedures with Contrast

This APG was completely redefined; all the original codes from this APG have been deleted. Codes were moved into this APG from the former non cardiac, non cerebral vascular APG, the digestive radiology APG and the former urography and genital radiology APG. This APG was changed from an ancillary APG to a significant procedure APG.

APG 365 [321] Anesthesia

There was no change to the definition of this APG. Several anesthesia codes were moved into this APG from the inpatient procedures APG.

APG 391 [332] Simple Pathology

There was no change in APG definition. Three pap smear codes were moved to a new pap smear APG, a few codes were moved to the complex pathology APG and the alimentary tests and simple tube placement APG. No codes were moved into this APG.

APG 392 [331] Complex Pathology

Several codes were moved out to the alimentary tests and simple tube placement APG. APG composition was expanded to include human tissue culture procedures.

APG 417 [341] Blood and Tissue Typing

This APG remained essentially unchanged; one code was moved out to the simple microbiology tests APG, no codes were moved in.

APG 418 [X] Human Tissue Culture

This APG was deleted; all codes were moved to the complex pathology APG.

APG 419 [343] Simple Immunology Tests

This APG remained essentially unchanged; one code was moved to the complex immunology tests APG.

APG 420 [342] Complex Immunology Tests

This APG essentially remained unchanged; one code was moved in, no codes were moved out.

APG 421 [345] Simple Microbiology Tests

This APG remained essentially unchanged; one code was moved to the complex microbiology tests APG.

APG 422 [344] Complex Microbiology Tests

There was very little change to this APG; three codes were moved out to the simple microbiology tests APG and one code was moved into this APG from the simple microbiology tests APG.

APG 423 [347] Simple Endocrinology Tests

Three codes were moved out of this APG; two went to the complex endocrinology tests APG and one to the complex chemistry tests APG.

APG 424 [346] Complex Endocrinology Tests

There were major changes to the code composition of this APG; although only one code was moved out to the simple endocrinolgy tests APG, most of the codes from the former radioimmunoassay tests APG were combined with this APG as were two codes from the simple endocrinology APG.

APG 425 [350] Basic Chemistry Tests

There was no change to this APG.

APG 426 [349] Simple Chemistry Tests

Three codes were moved out to the complex chemistry tests APG and one code to the simple endocrinology tests APG. Several codes were moved into this APG from the former radioimmunoassay tests APG and two codes were moved from the blood and urine dipstick tests APG.

APG 427 [348] Complex Chemistry Tests

There was relatively little code movement into or out of this APG; one code was moved out to the simple chemistry tests APG and a total of eight codes were moved in, four were from the radioimmunoassay tests APG and four from the simple chemistry and the simple endocrinology tests APGs.

428 [351] Multichannel Chemistry Tests

There was no change to this APG.

APG 429 [X] Simple Toxicology Tests

This APG was deleted; all codes were moved to the complex toxicology tests APG.

APG 430 [353] Complex Toxicology Tests

This APG is a combination of the simple and the complex toxicology tests APGs, the APG title was modified to Toxicology Tests,

APG 431 [359] Urinalysis

There was minimal change to this APG; one code was moved from this APG to the blood and urine dipstick tests APG.

APG 432 [354] Therapeutic Drug Monitoring

There was no change to this APG.

APG 433 [X] Radioimmunoassay Tests

This APG was deleted; all the codes were distributed among the four simple and complex chemistry and endocrinology tests APGs. Notably,

approximately seventy percent of the codes were placed into the complex endocrinology tests APG.

APG 434 [356] Simple Clotting Tests

This APG remained essentially unchanged; no codes were moved out, one code was moved into this APG from the complex clotting tests APG.

APG 435 [355] Complex Clotting Tests

This APG remained essentially unchanged; one code was moved out to the simple cotting tests APG, no codes were moved into this APG.

APG 436 [358] Simple Hematology Tests

There was no change to this APG.

APG 437 [357] Complex Hematology Tests

Two bone marrow aspiration and needle biopsy codes, 85095 and 85102, were moved out of this APG to the significant procedure APG for superficial needle biopsy and aspiration. One code was moved to the simple hematology tests APG.

APG 439 [X] Lithium Level Monitoring

This APG was deleted. The single code, 83725, which defined this APG has been deleted, it was replaced by code 80178 which is placed in the therapeutic drug monitoring APG.

APG 440 [360] Blood and Urine Dipstick Tests

Two codes were moved out to the simple chemistry tests APG and one code was moved into this APG from the urinalysis APG.

APG 443 [371] Spirometry and Respiratory Therapy

This APG was redefined; four codes were moved from this APG to the significant procedure APG for respiratory therapy and the APG title was changed to Simple Pulmonary Function Tests. No codes were moved into this APG.

APG 444 [372] Infusion Therapy Except Chemotherapy

There was no change to the definition of this APG; no codes were moved out, one code was moved into this APG from the introduction of needle and catheter APG.

APG 447 [373] Cardiogram

There was no change to the definition of this APG; no codes were moved out, three codes were moved into this APG from APG 469, Professional Service.

APG 449 [376] Simple Immunization

Three codes were moved from this APG to the moderate immunization APG and three were moved from the moderate immunization APG to this APG. The APG title was changed to Simple Immunization and Allergy Immunotherapy.

APG 450 [375] Moderate Immunization

There was considerable code movement into and out of this APG. Several codes were moved out of this APG to the simple immunization and the complex immunization APGs and several codes were also moved into this APG from those APGs.

APG 451 [374] Complex Immunization

There was minimal change to this APG; one code was moved out to the moderate immunization APG, no codes were moved in.

APG 452 [377] Minir Reproductive Procedures

There was no change to this APG.

APG 454 [379] Minor Doppler, ECG Monitoring & Ambulatory BP Monitoring Tests

This APG was divided into two APGs; forty percent of the codes were moved into a new pacemaker analysis APG, two vascular studies codes were moved from the significant procedure APG for simple urinary studies and procedures into this APG. The APG title was changed to Minor Cardiac and Vascular Tests.

APG 455 [379] Minor Opthalmological Injection, Scraping and Tests

There was minimal change to this APG; one code was moved out to the APG for services incidental to medical, significant procedure or therapy visits, no codes were moved in.

APG 456 [X] Vestibular Function Tests

This APG was deleted; the codes were distributed between two existing APGs, the significant procedure APG for otolaryngological function tests and the medical visit indicator APG.

APG 457 [381] Tube Change

This APG was redefined to include tube changes other than minor urinary. No codes were moved out of this APG, several codes for tube changes were moved into this APG from APGs representing other body systems.

APG 458 [X] Simple Anoscopy

This APG was deleted. One code was moved to the new APG for other miscellaneous ancillary procedures, the others were moved to the APG for services incidental to medical, significant procedure or therapy visits.

APG 459 [X] Biofeedback and Hypnotherapy

This APG was deleted. Many of the codes were incorporated into the new APG for biofeedback and other training.

APG 460 [382] Provision of Vision Aids

The definition of this APG was refined; several codes for the fitting of vision aids were moved out of this APG to the new APG for other miscellaneous ancillary procedures and to the APG for services incidental to medical, significant procedure or therapy visits.

APG 461 [383] Introduction of Needle and Catheter

There was considerable change to the code content of this APG; seventy percent of the original codes from this APG were distributed among nine significant procedure and ancillary APGs in multiple body systems or APG categories. The APG title was not changed.

INCIDENTAL PROCEDURE APGS

APG 469 [X] Professional Service

This APG was deleted. A significant number of the codes from this APG were assigned to the new medical visit indicator APG or the APG for services incidental to medical, significant procedure or therapy visits. The remaining codes from this APG were distributed among more than twelve other existing and new APGs in multiple APG categories and body systems.

APG 470 [286] Individual Psychotherapy

This incidental APG was restructured; the codes from this APG were assigned to the Counselling and Individual Brief Psychotherapy APG in the new significant procedure category for mental illness and substance abuse therapies.

APG 471 [289] Group Psychotherapy

This incidental APG was restructured; a new significant procedure APG was created in the mental illness and substance abuse therapies category.

APG 472 [411] Psychotropic Medication Management

This incidental APG was restructured; a new APG was created in the ancillary mental illness and substance abuse services category.

APG 473 [287] Comprehensive Psychiatric Evaluation and Treatment

One code was assigned to the new neuropsychiatric testing APG that was created in the mental illness and substance abuse therapies category; all other codes from this APG were assigned to the individual comprehensive psychotherapy APG.

APG 474 [288] Family Psychotherapy

This APG was restructured; a new significant procedure APG was created in the mental illness and substance abuse therapies category.

APG 475 [X] Radiological Supervision and Interpretation Only

This APG was deleted. A significant number of the codes from this APG were assigned to the significant procedure APGs for vascular radiology except for venography of extremity and for miscellaneous radiological procedures with contrast. Other codes were distributed among several significant procedure APGs in specific body systems and other radiological APGs. Three codes were assigned to the APG for services incidental to medical, significant procedures or therapy visits.

APG 478 [311] Therapeutic Radiology Planning and Device Construction

One code was moved to the APG for incidental services. The APG title was changed to Therapeutic Radiation Treatment Preparation.

APG 500 [391] Class One Chemotherapy Drugs

Several codes were moved out of this APG to the class two and class three chemotherapy drugs APGs.

APG 501 [392] Class Two Chemotherapy Drugs

Codes from this APG were moved up to the class three chemotherapy drugs APG and to new class four and class five chemotherapy drugs APGs; one code was moved down to this APG from the class three chemotherapy drugs APG.

APG 502 [393] Class Three Chemotherapy Drugs

One code was moved down to the class two chemotherapy drugs APGs, the remainder of the codes from this APG were moved to a new APG for class four chemotherapy drugs. This APG was then reformulated from codes which had been moved up from the class one and the class two chemotherapy drugs APGs.

MEDICAL APGS

APG 601 [431] Hematological Malignancy

There was no change to this APG.

APG 602 [432] Prostatic Malignancy

There was no change to this APG.

APG 603 [433] Lung Malignancy

There was no change to this APG.

APG 604 [436] Skin Malignancy

There was no change to this APG.

APG 605 [437] Malignancies Except Hematological, Prostatic, Lung and Skin

This APG was completely restructured; two new APGs for breast malignancies and skin malignancies were formed with codes which were removed from this APG. Two codes were also moved to the lung malignancy APG. The APG title was changed to Other Malignancies.

APG 616 [451] Poisoning

There was no change to this APG.

APG 631 [461] Head and Spine Injury

There was no change to this APG.

APG 632 [463] Burns and Skin and Soft Tissue Injury

This APG was redefined and restructured. All burn codes were moved to a new APG specifically for burns; nine codes were moved to the APG for other injuries and one code to the aftercare APG. The remainder of the codes from this APG were divided between two APGs: Skin and Soft Tissue Injuries Except Burns, and Minor Skin and Soft Tissue Injuries Except Burns.

APG 633 [464] Fracture, Dislocation and Sprain

This APG remained essentially unchanged, one code was moved to the aftercare APG.

APG 634 [466] Other Injuries

There was minimal change to this APG, one code was moved to the eye diseases APG and several codes were moved into this APG from the skin and soft tissue injury APG.

APG 654 [X] Individual Supportive Treatment for Senility, Dementia & Mental Retardation

This APG was deleted.

APG 655 [X] Psychotropic Medication Management and Brief Psychotherapy

This APG was deleted.

APG 656 [X] Comprehensive Psychiatric Evaluation and Treatment Age > 17

This APG was deleted.

APG 657 [X] Comprehensive Psychiatric Evaluation and Treatment Age 0-17

This APG was deleted.

APG 658 [X] Family Psychotherapy

This APG was deleted.

APG 659 [X] Group Psychotherapy

This APG was deleted.

APG 664 [X] Comprehensive Therapy for Drug Abuse with Mental Illness

This APG was deleted

APG 667 [X] Comprehensive Therapy for Drug Abuse without Mental Illness

This APG was deleted

PG 668 [X] Medication Management and Brief Psychotherapy for Drug Abuse

This APG was deleted.

APG 669 [X] Family Therapy for Drug Abuse

This APG was deleted.

APG 670 [X] Group Therapy for Drug Abuse

This APG was deleted.

APG 676 [481] Neonate and Congenital Anomaly

There was no change to this APG.

APG 691 [491] Routine Prenatal Care

There was no change to the definition of this APG; several codes were moved into this APG from the maternal antepartum complication APG.

APG 692 [492] Maternal Antepartum Complication

Several codes were moved from this APG to the routine prenatal care APG.

APG 693 [493] Routine Postpartum Care

There was no change to the definition of this APG; several codes were moved into this APG from the maternal postpartum complication APG.

APG 694 [494] Maternal Postpartum Complication

Several codes were moved from this APG to the routine postpartum care APG.

APG 721 [502] Systemic Infectious Disease

This APG was redefined. Several codes representing septicemia and other conditions were removed from this APG and assigned to a new APG for complex infectious disease; a few codes were moved to the skin diseases APG. The title of this APG was changed to Miscellaneous Infectious Diseases.

APG 723 [X] Sexually Transmitted Disease in Males

This APG was deleted; The codes from this APG were moved to the new APG for infectious diseases of genital organs.

APG 724 [X] Sexually Transmitted Disease in Females

This APG was deleted; The codes from this APG were moved to the new APG for infectious diseases of genital organs.

APG 736 [511] TIA, CVA and Other Cerebrovascular Event

There was no change to this APG.

APG 737 [512] Headache

There was no change to this APG.

APG 738 [515] Central Nervous System Diseases Except TIA, CVA and Headache

Epilepsy codes were removed from this APG and assigned to a new APG specifically for epilepsy; two codes were removed from this APG and assigned to a new APG for non traumatic loss of consciousness; one code, sudden infant death syndrome, was moved to the new APG for unknown

cause of death. The title of this APG was changed to Other Diseases of the Nervous System.

APG 751 [531] Cataracts

There was no change to this APG.

APG 752 [532] Refraction Disorder

There was no change to this APG.

APG 753 [533] Conjunctivitis and Other Simple External Eye Inflammation

There was no change to this APG.

APG 754 [534] Eye Diseases Except Cataract, Refraction Disorder & Conjunctivitis

Several codes were moved out of this APG to the Other Injuries APG and one code was moved to the new APG for aftercare. Only one code was moved into this APG, from the Other Injuries APG.

APG 766 [541] Dental Disease

There was no change to this APG.

APG 767 [542] Acute Infectious Ear, Nose and Throat Disease Age >17

There was significant change to the definition of this APG. The age distinction was removed and the title was changed to Influenza, URI and ENT Infections. One code was moved to the APG for other simple ear, nose, throat and mouth diseases.

APG 768 [X] Acute Infectious Ear, Nose and Throat Disease Age 0-17

This APG was eliminated.

APG 769 [X] Acute Non Infectious Ear, Nose and Throat Disease

This APG was deleted; the codes were distributed between the two APGs for other complex and other simple ear, nose, throat and mouth diseases.

APG 771 [543] Hearing Loss

There was no change to this APG.

APG 772 [545] Other Ear, Nose, Throat and Mouth Diseases

This APG was redefined and the code content was restructured. Approximately one third of the codes, representing more complex conditions, were removed from this APG and assigned to a new APG for Other Complex

Ear, Nose, Throat and Mouth Diseases. The majority of the codes remained in this APG with a title change to Other Simple Ear, Nose, Throat and Mouth Diseases. Thus code 5270, Salivary gland atrophy, was placed into the Simple ENT APG while code 74401, Congenital absence of external ear, was placed in the complex ENT diseases APG.

APG 781 [561] Emphysema, Chronic Bronchitis and Asthma, Age > 17

The definition of this APG was revised to remove the age distinction, consequently the title was revised to delete the age reference. Only one code was moved into this APG from the APG for other respiratory diseases, no codes were moved out of this APG.

APG 782 [561] Emphysema, Chronic Bronchitis and Asthma, Age 0-17

This APG was deleted.

APG 783 [562] Pneumonia

There was no change to this APG.

APG 784 [564] Respiratory Disease Except Emphysema, Chronic Bronchitis & Asthma

There was significant change to the definition and code composition of this APG. Ninety percent of the codes were removed and assigned to a new APG for complex respiratory diseases except emphysema, chronic bronchitis and asthma and one code was moved to the emphysema, chronic bronchitis and asthma APG. The title of this APG was changed to Simple Respiratory Disease Except Emphysema, Chronic Bronchitis and Asthma. Thus, code 2142, Lipoma intrathoracic, was placed into the simple respiratory APG while code 01106, TB, pneumonia, was placed in the complex respiratory APG.

APG 796 [571] Congestive Heart Failure and Ischemic Heart Disease

Several chest pain codes were removed from this APG and were used to define two new APGs for chest pain with and without cardiac enzymes to rule out Myocardial Infarction. This was done to recognize differences in the resource consumption between patients presenting with chest pain to the emergency room and outpatient department. More patients with chest pain are evaluated with cardiac enzymes in the emergency room than in the outpatient department.

APG 797 [572] Hypertension

The APG for hypertension was unchanged except that several codes were moved out and placed into the congestive heart failure APG. For example, code 40201, Malignant hypertensive heart disease with congestive heart failure was moved from the hypertension APG to the congestive heart failure APG.

APG 800 [575] Cardiovascular Disease Except CHF, Ischemic Heart Disease & Hypertension

There was considerable change to the definition and code composition of this APG. More than half of the codes were removed and assigned to a new APG for complex cardiovascular disease except CHF, ischemic heart disease and hypertension. The title of this APG was changed to Simple Cardiovascular Disease Except CHF, Ischemic Heart Disease & Hypertension. Thus, code 42611, Atrioventricular block-1st degree, was placed into the simple cardiovascular disease APG while code 4254, Primary cardiomyopathy, was placed in the complex cardiovascular disease APG. Two codes representing diabetes mellitus with circulatory disorders were moved to the diabetes APG.

APG 811 [591] Noninfectious Gastroenteritis

There was no change to this APG.

APG 812 [592] ulcers, Gastritis and Esophagitis

This APG remained essentially unchanged; one code, for dysphagia, was moved into this APG from the APG for other gastrointestinal diseases.

APG 813 [X] Functional Gastrointestinal Disease and Irritable Bowel Syndrome

This APG was deleted; all codes were assigned to the APG for other gastrointestinal diseases.

APG 814 [593] Hepatobiliary Disease

There was no change to this APG.

APG 816 [595] Hemorrhoids and Other Anal-Rectal Diseases

There was no change to this APG.

APG 817 [597] Other Gastrointestinal Diseases

There was significant change to the definition and code composition of this APG. All the hernia codes were removed and assigned to a new APG specifically for hernia. Fifty percent of the original codes from this APG were assigned to a new APG for other complex gastrointestinal diseases and the title of this APG was changed to Other Simple Gastrointestinal Diseases. Thus, code 0071, Giardiasis, was placed into the other simple gastrointestinal diseases APG while code 5550, Regional enteritis, was placed in the other complex gastrointestinal diseases APG.

APG 827 [611] Major Signs, Symptoms And Findings

One code 7854, Gangrene, moved out of this APG to the Simple Cardiovascular Diseases APG. Only one code, 9950, Analphylactic shock, was moved to the APG for Major Signs, Symptoms and Findings.

APG 841 [621] Back Disorders

There was no change to this APG.

APG 842 [623] Musculoskeletal Diseases Except Back Disorders

There was significant change to this APG. Approximately forty percent of the codes from this APG were removed and assigned to a new APG for complex musculoskeletal diseases except back disorders and the title of this APG was changed to Simple Musculoskeletal Diseases Except Back Disorders. Thus, code 3060, Psychogenic musculoskeletal disease, was placed into the simple musculoskeletal diseases APG while code 71140, Bacterial arthritis, was placed in the complex musculoskeletal diseases APG.

APG 856 [631] Disease of Nails

There was no change to this APG.

APG 857 [632] Chronic Skin Ulcer

There was no change to this APG.

APG 858 [633] Cellulitis, Impetigo and Lymphangitis

There was no change to this APG.

APG 859 [634] Breast Diseases

There was no change to this APG.

APG 860 [635] Other Skin Diseases

There was minimal change to this APG. No codes were moved out of this APG, a few codes were moved in; for example, one code, 1179, Mycoses NEC and NOS, was moved from an infectious disease APG to this APG as other simple fungal diseases were already in this skin disease APG.

APG 871 [651] Diabetes

Two hypoglycemia codes were moved from the APG for Diabetes to a new APG for Complex Endocrine, Nutritional & Metabolic Disease Except Diabetes and Obesity and two diabetic related cardiovascular complication codes were moved in from the cardiovascular disease APG.

APG 872 [X] Obesity

This APG was deleted; the obesity and dietary counselling codes were assigned to the APG for simple endocrine, nutritional and metabolic diseases.

APG 873 [653] Endocrine, Nutritional & Metabolic Disease Except Diabetes & Obesity

There was significant change to the definition and code composition of this APG. Almost fifty percent of the codes were assigned to a new APG for complex endocrine, nutritional and metabolic disease except diabetes and obesity; the title of this APG was changed to Simple Endocrine, Nutritional and Metabolic Disease Except Diabetes. Thus, code 2400, Simple goiter, was placed into the simple endocrine APG while code 2271, Benign neoplasm of the pituitary, was placed in the complex endocrine APG. A new Fluid and Electrolyte Disorder APG was created as many patients who come in specifically for this type of problem are seen in the emergency room.

APG 886 [661] Urinary Tract Infection

There was no change to this APG.

AG 887 [662] Renal Failure

There was no change to this APG.

APG 888 [664] Urinary Disease Except Urinary Tract Infection & Renal Failure

There was significant change to the definition and code composition of this APG.More than half of the codes were split off from this APG and assigned to a new APG for complex urinary disease except urinary tract infection and renal failure; the title of this APG was changed to Simple Urinary Disease Except Urinary Tract Infection and Renal Failure. Thus, code 7881, Dysuria, was placed into the simple urinary disease APG while code 5809, Acute nephritis NOS, was placed in the complex urinary disease APG.

APG 901 [671] Benign Prostatic Hypertrophy

There was no change to this APG.

APG 902 [672] Male Reproductive Diseases Except Benign Prostatic Hypertrophy

There was minimal change to this APG; a few codes representing congenital anomalies of genital organs which are not specific to the male reproductive system were moved to the APG for neonate and congenital anomaly. One code, 6981, Pruritis of genitalia, was moved to the skin diseases APG.

APG 916 [681] Gynecologic Diseases

There was no change to the APG for Gynecologic Diseases

APG 932 [691] AIDS Related Complex and HIV Infection with Complications

All the original codes in this APG have been deleted, this APG now consists of all new codes. The APG title was changed to HIV Infection.

APG 933 [694] Other Immunologic and Hematologic Disease

There was significant change to the definition and code composition of this APG. Several codes representing nutritional anemias and sickle cell in crisis were removed from this APG and assigned to a new APG for anemia. Two codes for anaphylactic shock were moved to the major signs, symptoms and findings APG and two infectious disease codes were moved to the miscellaneous infectious diseases APG. The remaining codes in this APG were divided with more than fifty percent being assigned to a new APG for other complex immunologic and hematologic disease, the title of this APG was changed to Other Simple Immunologic and Hematologic Disease. Thus, code 28950, Spleen disease NOS, was placed into the simple immunologic and hematologic disease APG while code 2773, Amyloidosis, was placed in the APG for other complex immunologic and hematologic disease.

APG 946 [701] Adult Medical Examination

There was minimal change to this APG; a few codes were moved from this APG to a new Aftercare APG which was created to account for visits for largely surgical follow-up.

APG 947 [702] Well Child Care

There was no change to this APG.

APG 948 [X] Counseling

This APG was deleted. All codes were assigned to the new mental illness and substance abuse therapy APG for counselling or individual brief psychotherapy.

APG 949 [703] Contraception and Procreative Management

There was no change to this APG.

APG 950 [X] Repeat Prescription

This APG was deleted; the repeat prescription code was assigned to the new Aftercare APG.

APG 951 [705] Nonspecific Signs & Symptoms & Other Contacts with Health Services

There was no change to the definition of this APG but there was considerable code movement in and out. Several codes were moved from this APG to the new APGs for chest pain and for aftercare, one code was moved to the simple

gastrointestinal diseases APG. A significant number of codes which could represent visits where a planned procedure was cancelled, were moved into this APG from the error APG.

APG 959 [X] Admitted or Died

This APG was deleted.

APG 999 [999] Error

There was significant change within the error APG category. Significant error conditions along with associated groups of diagnosis or procedure codes were assigned to specific APGs creating seven additional error APGs. There was also some movement of codes into and out of the error category. Of note, approximately two percent of the procedures previously labelled as inpatient procedures were moved out to other significant procedure APGs as they were occasionally performed on an outpatient basis. A smaller number of codes were considered too complex to be performed as outpatient procedures and were moved from other significant procedure APGs into the inpatient procedure error APG. Several codes representing panels of laboratory tests were removed from the error APG category and assigned to a new ancillary laboratory procedures APG for organ or disease oriented panels and several codes for sudden, unattended and instantaneous death were assigned to a new medical APG for unknown cause of mortality.

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APPENDIX K

Lists of Version 1.0 and 2.0 APGs by Type of Modification

The Following APGs are Unchanged from V1.0 to V2.0

V1.0	V2.0	DESCRIPTION
58	27	SPLINT, STRAPPING AND CAST REMOVAL
67	32	BUNION PROCEDURES
71	34	HAND AND FOOT TENOTOMY
76	35	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION
77	273	SPEECH THERAPY
167	236	TONSIL AND ADENOID PROCEDURES
186	139	HEMODIALYSIS
187	140	PERITONEAL DIALYSIS
213	155	PROSTATE NEEDLE AND PUNCH BIOPSY
238	174	THERAPEUTIC ABORTION
262	193	ELECTROCONVULSIVE THERAPY
272	199	SPINAL TAP
343	251	THERAPEUTIC NUCLEAR MEDICINE
428	351	MULTICHANNEL CHEMISTRY TESTS
602	432	PROSTATIC MALIGNANCY
604	436	SKIN MALIGNANCY
616	451	POISONING
631	461	HEAD AND SPINE INJURY
751	531	CATARACTS
752	532	REFRACTION DISORDER
771	543	HEARING LOSS
811	591	NONINFECTIOUS GASTROENTERITIS
816	595	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
841	621	BACK DISORDERS
856	631	DISEASE OF NAILS
857	632	CHRONIC SKIN ULCER
858	633	CELLULITIS, IMPETIGO AND LYMPHANGITIS
859	634	BREAST DISEASES
886	661	URINARY TRACT INFECTION
887	662	RENAL FAILURE
901	671	BENIGN PROSTATIC HYPERTROPHY
902	672	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY
947	702	WELL CHILD CARE

The Following APGs are Unchanged from V1.0 to V2.0 Except that Deleted HCPCS Codes were Removed and New HCPCS Codes were Added

V1.0	V2.0	DESCRIPTION
1	1	PHOTOCHEMOTHERAPY
28	12	BREAST RECONSTRUCTION AND MASTECTOMY
53	271	OCCUPATIONAL THERAPY
54	272	PHYSICAL THERAPY
105	71	EXERCISE TOLERANCE TESTS
106	72	ECHOCARDIOGRAPHY
115	81	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
116	82	VASCULAR LIGATION
117	83	RESUSCITATION AND CARDIOVERSION
131	91	CHEMOTHERAPY BY EXTENDED INFUSION
134	94	BLOOD AND BLOOD PRODUCT EXCHANGE
158	112	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
161	114	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
168	119	HERNIA AND HYDROCELE PROCEDURES
171	120	COMPLEX ANAL AND RECTAL PROCEDURES
237	173	TREATMENT OF SPONTANEOUS ABORTION
239	175	VAGINAL DELIVERY
243	178	DILATION AND CURETTAGE
291	214	CATARACT PROCEDURES
318	237	SIMPLE AUDIOMETRY
345	304	OBSTETRICAL ULTRASOUND
348	306	MAGNETIC RESONANCE IMAGING
350	308	MAMMOGRAPHY
425	350	BASIC CHEMISTRY TESTS
432	354	THERAPEUTIC DRUG MONITORING
601	431	HEMATOLOGICAL MALIGNANCY
676	481	NEONATE AND CONGENITAL ANOMALY
736	511	TIA, CVA AND OTHER CEREBROVASCULAR EVENTS
737	512	HEADACHE
753	533	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION
766	541	DENTAL DISEASE
783	562	PNEUMONIA
814	593	HEPATOBILIARY DISEASE
916	681	GYNECOLOGIC DISEASES
932	691	HIV INFECTION
949	703	CONTRACEPTION AND PROCREATIVE MANAGEMENT

The Following APGs are NEW for APG 2.0

APG	DESCRIPTION
21	COMPLEX MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
22	SIMPLE MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
23	COMPLEX HAND AND FOOT MUSCULOSKELETAL PROCEDURES
24	SIMPLE HAND AND FOOT MUSCULOSKELETAL PROCEDURES
57	RESPIRATORY THERAPY
84	CARDIAC REHABILITATION
97	TRANSFUSION
123	COMPLEX LAPAROSCOPIC PROCEDURES
124	SIMPLE LAPAROSCOPIC PROCEDURES
136	SIMPLE CYSTOURETHROSCOPY
179	HYSTEROSCOPY
191	EXTENDED EEG STUDIES
223	VITRECTOMY
231	COCHLEAR DEVICE IMPLANTATION
234	COMPLEX FACIAL AND ENT PROCEDURES
235	SIMPLE FACIAL AND ENT PROCEDURES
281	NEUROPSYCHOLOGICAL TESTING
282	FULL DAY PARTIAL HOSPITALIZAATION FOR SUBSTANCE ABUSE
283	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
284	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
285	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
302	INTERMEDIATE DIAGNOSTIC NUCLEAR MEDICINE
333	PAP SMEARS
352	ORGAN OR DISEASE ORIENTED PANELS
380	PACEMAKER ANALYSIS
384	DRESSINGS AND OTHER MINOR PROCEDURES
385	OTHER MISCELLANEOUS ANCILLARY PROCEDURES
386	BIOFEEDBACK AND OTHER TRAINING
394	CLASS FOUR CHEMOTHERAPY DRUGS
395	CLASS FIVE CHEMOTHERAPY DRUGS
412	ACTIVITY THERAPY
421	INCIDENTAL TO MEDICAL,SIGNIFICANT PROCEDURE OR THERAPY VISIT
422	MEDICAL VISIT INDICATOR
434	BREAST MALIGNANCIES
435	GI MALIGNANCIES
462	MINOR SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
465	BURNS
501	COMPLEX INFECTIOUS DISEASES
503	INFECTIOUS DISEASES OF GENITAL ORGANS
513	EPILEPSY
514	NON TRAUMATIC LOSS OF CONSCIOUSNESS
544	OTHER, COMPLEX EAR, NOSE, THROAT AND MOUTH DISEASES
563	COMPLEX RESPIRATORY DIS EXC EMPHYSEMA, CHR BRONCHITIS & ASTHMA
573	CHEST PAIN W CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT

The Following APGs are NEW for APG 2.0 (Continued)

APG	DESCRIPTION
574	CHEST PAIN WO CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
576	COMPLEX CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
594	HERNIA
596	OTHER COMPLEX GASTROINTESTINAL DISEASES
622	COMPLEX MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
652	COMPLEX ENDOCRINE,NUTRIT & METABOLIC DIS EXC DIABETES & OBESITY
654	FLUID AND ELECTROLYTE DISORDERS
663	COMPLEX URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
692	ANEMIA
693	OTHER COMPLEX IMMUNOLOGIC AND HEMATOLOGIC DISEASE
704	AFTERCARE
721	UNKNOWN CAUSE OF MORTALITY
000	ERRORS
992	INVALID PROCEDURE CODE
993	INPATIENT PROCEDURE
994	AUTOPSY SERVICES
995	CARE SETTING OTHER THAN OUTPATIENT
996	INVALID RVDX CODE
997	E CODE CANNOT BE USED AS RVDX
998	UNACCEPTABLE RVDX, REQUIRES PROCEDURE

The Following APGs were Modified in Version 2.0

V1.0	V2.0	DESCRIPTION
2	002	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
4	003	COMPLEX INCISION AND DRAINAGE
3	004	SIMPLE INCISION AND DRAINAGE
5	005	NAIL PROCEDURES
6	006	SIMPLE DEBRIDEMENT AND DESTRUCTION
8	007	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
7	008	SIMPLE EXCISION AND BIOPSY
11	009	COMPLEX SKIN REPAIRS INCL INTEGUMENT GRAFTS, TRANSFER & REARRANGE
10	010	SIMPLE SKIN REPAIR
27	011	SIMPLE INCISION AND EXCISION OF BREAST
56	025	ARTHROSCOPY
57	026	REPLACEMENT OF CAST
59	028	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK
60	029	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK
62	030	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES
63	031	BONE OR JOINT MANIPULATION UNDER ANESTHESIA
70	033	ARTHROPLASTY
79	051	PULMONARY TESTS
80	052	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION
82	053	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY
81	054	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
84	055	ENDOSCOPY OF THE LOWER AIRWAY
107	073	PHONOCARDIOGRAM
108	074	CARDIAC ELECTROPHYSIOLOGIC TESTS
109	075	PLACEMENT OF TRANSVENOUS CATHETERS.
110	076	DIAGNOSTIC CARDIAC CATHETERIZATION
111	077	ANGIOPLASTY AND TRANSCATHETER PROCEDURES
112	078	PACEMAKER INSERTION AND REPLACEMENT
113	079	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
114	080	MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
132	092	CHEMOTHERAPY EXCEPT BY EXTENDED INFUSION
133	093	PHLEBOTOMY
135	095	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
136	096	ALLERGY TESTS
157	111	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
160	113	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
162	115	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION
163	116	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION
165	117	LOWER GASTROINTESTINAL ENDOSCOPY
166	118	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES
170	121	SIMPLE ANAL AND RECTAL PROCEDURES
173	122	MISCELLANEOUS ABDOMINAL PROCEDURES
184	131	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
183	132	SIMPLE URINARY STUDIES AND PROCEDURES

The Following APGs were Modified in Version 2.0 (Continued)

V1.0	V2.0	DESCRIPTION
185	133	URINARY CATHETERIZATION AND DILATATION
189	134	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAXY
188	135	MODERATE CYSTOURETHROSCOPY
193	137	COMPLEX URETHRAL PROCEDURES
192	138	SIMPLE URETHRAL PROCEDURES
209	151	TESTICULAR AND EPIDIDYMAL PROCEDURES
210	152	INSERTION OF PENILE PROSTHESIS
211	153	COMPLEX PENILE PROCEDURES
212	154	SIMPLE PENILE PROCEDURES
235	171	ARTIFICIAL FERTILIZATION
236	172	PROCEDURES FOR PREGNANCY AND NEONATAL CARE
244	176	COMPLEX FEMALE REPRODUCTIVE PROCEDURES
242	177	SIMPLE FEMALE REPRODUCTIVE PROCEDURES
241	180	COLPOSCOPY
261	192	ELECTROENCEPHALOGRAM
263	194	NERVE AND MUSCLE TESTS
266	195	NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP
267	196	REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
268	197	NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
270	198	NERVE REPAIR AND DESTRUCTION
287	211	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
288	212	FITTING OF CONTACT LENSES
290	213	LASER EYE PROCEDURES
296	215	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES
295	216	MODERATE ANTERIOR SEGMENT EYE PROCEDURES
292	217	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES
298	218	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
297	219	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
299	220	STRABISMUS AND MUSCLE EYE PROCEDURES
301	221	COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE
300	222	SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
313	232	OTORHINOLARYNGOLOGIC FUNCTION TESTS
85	233	NASAL CAUTERIZATION AND PACKING
344	252	RADIATION THERAPY AND HYPERTHERMIA
353	253	VASCULAR RADIOLOGY EXCEPT FOR VENOGRAPHY OF EXTREMITY
359	254	MYELOGRAPHY
360	255	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
470	286	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
472	411	PSYCHOTROPIC MEDICATION MANAGEMENT
473	287	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY
474	288	FAMILY PSYCHOTHERAPY
471	289	GROUP PSYCHOTHERAPY
342	301	COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
341	303	SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
346	305	DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL

The Following APGs were Modified in Version 2.0 (Continued)

V1.0	V2.0	DESCRIPTION
349	307	COMPUTERIZED AXIAL TOMOGRAPHY
356	309	DIGESTIVE RADIOLOGY
351	310	PLAIN FILM
365	321	ANESTHESIA
392	331	COMPLEX PATHOLOGY
391	332	SIMPLE PATHOLOGY
417	341	BLOOD AND TISSUE TYPING
420	342	COMPLEX IMMUNOLOGY TESTS
419	343	SIMPLE IMMUNOLOGY TESTS
422	344	COMPLEX MICROBIOLOGY TESTS
421	345	SIMPLE MICROBIOLOGY TESTS
424	346	COMPLEX ENDOCRINOLOGY TESTS
423	347	SIMPLE ENDOCRINOLOGY TESTS
427	348	COMPLEX CHEMISTRY TESTS
426	349	SIMPLE CHEMISTRY TESTS
430	353	TOXICOLOGY TESTS
435	355	COMPLEX CLOTTING TESTS
434	356	SIMPLE CLOTTING TESTS
437	357	COMPLEX HEMATOLOGY TESTS
436	358	SIMPLE HEMATOLOGY TESTS
431	359	URINALYSIS
440	360	BLOOD AND URINE DIPSTICK TESTS
443	371	SIMPLE PULMONARY FUNCTION TESTS
444	372	INFUSION THERAPY EXCEPT CHEMOTHERAPY
447	373	CARDIOGRAM
451	374	COMPLEX IMMUNIZATION
450	375	MODERATE IMMUNIZATION
449	376	SIMPLE IMMUNIZATION AND ALLERGY IMMUNOTHERAPY.
452	377	MINOR REPRODUCTIVE PROCEDURES
454	378	MINOR CARDIAC AND VASCULAR TESTS
455	379	MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
457	381	TUBE CHANGE
460	382	PROVISION OF VISION AIDS
461	383	INTRODUCTION OF NEEDLE AND CATHETER
478	311	THERAPEUTIC RADIATION TREATMENT PREPARATION
500	391	CLASS ONE CHEMOTHERAPY DRUGS
501	392	CLASS TWO CHEMOTHERAPY DRUGS
502	393	CLASS THREE CHEMOTHERAPY DRUGS
603	433	LUNG MALIGNANCY
605	437	OTHER MALIGNANCIES
632	463	SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
633	464	FRACTURE, DISLOCATION AND SPRAIN
634	466	OTHER INJURIES
691	491	ROUTINE PRENATAL CARE
692	492	MATERNAL ANTEPARTUM COMPLICATION

The Following APGs were Modified in Version 2.0 (Continued)

V1.0	V2.0	DESCRIPTION
693	493	ROUTINE POSTPARTUM CARE
694	494	MATERNAL POSTPARTUM COMPLICATION
721	502	MISCELLANEOUS INFECTIOUS DISEASES
738	515	OTHER DISEASES OF THE NERVOUS SYSTEM
754	534	EYE DISEASES EXCEPT CATARACT,REFRACTION DISORDER & CONJUNCTIVITIS
767	542	INFLUENZA, URI AND ENT INFECTIONS.
772	545	OTHER SIMPLE EAR, NOSE, THROAT AND MOUTH DISEASES
781	561	EMPHYSEMA, CHRONIC BRONCHITIS, AND ASTHMA.
784	564	SIMPLE RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
796	571	CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
797	572	HYPERTENSION
800	575	SIMPLE CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
812	592	ULCERS, GASTRITIS AND ESOPHAGITIS
817	597	OTHER SIMPLE GASTROINTESTINAL DISEASES
827	611	MAJOR SIGNS, SYMPTOMS AND FINDINGS
842	623	SIMPLE MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
860	635	SKIN DISEASES
871	651	DIABETES
873	653	SIMPLE ENDOCRINE, NUTRITIONAL & METABLIC DISEASE EXC DIABETES
888	664	SIMPLE URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
933	694	OTHER SIMPLE IMMUNOLOGIC AND HEMATOLOGIC DISEASE
946	701	ADULT MEDICAL EXAMINATION
951	705	NONSPECIFIC SIGNS & SYMPTOMS & OTH CONTACTS W HEALTH SVCS
ERRORS		
999	993	INPATIENT PROCEDURE
999	998	UNACCEPTABLE RVDX, REQUIRES PROCEDURE
999	999	UNGROUPABLE

The Following V1.0 APGs have been Deleted

APG	DESCRIPTION
9	LIPECTOMY AND EXCISION WITH RECONSTRUCTION
12	SKIN AND INTEGUMENT GRAFT, TRANSFER AND REARRANGEMENT
55	DIAGNOSTIC ARTHROSCOPY
64	SIMPLE MAXILLOFACIAL PROCEDURES
65	COMPLEX MAXILLOFACIAL PROCEDURES
66	INCISION OF BONE,JOINT AND TENDON
68	EXCISION OF BONE, JOINT AND TENDON OF THE HAND AND FOOT
69	EXCISION OF BONE, JOINT & TENDON EXCEPT HAND & FOOT
72	SIMPLE HAND AND FOOT REPAIR EXCEPT TENOTOMY
73	COMPLEX HAND AND FOOT REPAIR
74	REPAIR,EXCEPT ARTHROTOMY OF BONE,JOINT,TENDON EXCEPT OF HAND AND FOOT
75	ARTHROTOMY EXCEPT OF HAND AND FOOT
83	SIMPLE ENDOSCOPY OF THE LOWER AIRWAY
86	SIMPLE LIP, MOUTH AND SALIVARY GLAND PROCEDURES
87	COMPLEX LIP, MOUTH AND SALIVARY GLAND PROCEDURES
88	MISCELLANEOUS SINUS, TRACHEAL AND LUNG PROCEDURES
159	PERCUTANEOUS AND OTHER SIMPLE GASTROINTESTINAL BIOPSY
164	DIAGNOSTIC LOWER GASTROINTESTINAL ENDOSCOPY
169	SIMPLE HEMORRHOID PROCEDURES
172	PERITONEAL PROCEDURES AND CHANGE OF INTRA-ABDOMINAL TUBE
190	PERCUTANEOUS RENAL ENDOSCOPY,CATHETERIZATION & URETERAL ENDOSCOPY
191	CYSTOTOMY
214	TRANSURETHRAL RESECTION OF PROSTATE & OTHER PROSTATE PROCEDURES
240	FEMALE GENITAL ENDOSCOPY
264	INJECTION OF SUBSTANCE INTO SPINAL CORD
265	SUBDURAL AND SUBARACHNOID TAP
269	CARPAL TUNNEL RELEASE
271	COMPLEX NERVE REPAIR
289	SIMPLE LASER EYE PROCEDURES
293	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES FOR GLAUCOMA
294	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES EXCEPT FOR GLAUCOMA
314	MAJOR EXTERNAL EAR PROCEDURES
315	TYMPANOSTOMY AND OTHER SIMPLE MIDDLE EAR PROCEDURES
316	TYMPANOSTOMY AND OTHER COMPLEX MIDDLE EAR PROCEDURES
317	INNER EAR PROCEDURES
319	REMOVAL OF IMPACTED CERUMEN
347	HYPERTHERMIA
352	FLUOROSCOPY
354	VENOGRAPHY OF EXTREMITY
355	NON-CARDIAC,NON-CEREBRAL VASCULAR RADIOLOGY
357	UROGRAPHY AND GENITAL RADIOLOGY
358	ARTHROGRAPHY
418	HUMAN TISSUE CULTURE
429	SIMPLE TOXICOLOGY TESTS

The Following V1.0 APGs have been Deleted (Continued)

APG	DESCRIPTION
433	RADIOIMMUNOASSAY TESTS
439	LITHIUM LEVEL MONITORING
456	VESTIBULAR FUNCTION TESTS
458	SIMPLE ANOSCOPY
459	BIOFEEDBACK AND HYPNOTHERAPY
469	PROFESSIONAL SERVICE
475	RADIOLOGICAL SUPERVISION AND INTERPRETATION ONLY
654	INDIVIDUAL SUPPORTIVE TREATMENT FOR SENILITY,DEMENTIA & MENTAL RETARD
655	PSYCHOTROPIC MEDICATION MANAGEMENT AND BRIEF PSYCHOTHERAPY
656	COMPREHENSIVE PSYCHIATRIC EVALUATION AND TREATMENT AGE > 17
657	COMPREHENSIVE PSYCHIATRIC EVALUATION AND TREATMENT AGE 0-17
658	FAMILY PSYCHOTHERAPY (MED APG)
659	GROUP PSYCHOTHERAPY (MED APG)
664	COMPREHENSIVE THERAPY FOR DRUG ABUSE WITH MENTAL ILLNESS
667	COMPREHENSIVE THERAPY FOR DRUG ABUSE WITHOUT MENTAL ILLNESS
668	MEDICATION MANAGEMENT AND BRIEF PSYCHOTHERAPY FOR DRUG ABUSE
669	FAMILY THERAPY FOR DRUG ABUSE
670	GROUP THERAPY FOR DRUG ABUSE
723	SEXUALLY TRANSMITTED DISEASE IN MALES
724	SEXUALLY TRANSMITTED DISEASE IN FEMALES
768	ACUTE INFECTIOUS EAR,NOSE AND THROAT DISEASE AGE 0-17
769	ACUTE NONINFECTIOUS EAR,NOSE AND THROAT DISEASE
782	EMPHYSEMA,CHRONIC BRONCHITIS AND ASTHMA AGE 0-17
813	FUNCTIONAL GASTROINTESTINAL DISEASE AND IRRITABLE BOWEL SYNDROME
872	OBESITY
948	COUNSELLING
950	REPEAT PRESCRIPTION
959	ADMITTED OR DIED

APPENDIX L

List of Version 2.0 APGs

The Version 2.0 APGs have been divided into 46 Ambulatory Patient Categories (APCs). The Appendix contains a complete list of APCs and APGs for Version 2.0.

SIGNIFICANT PROCEDURE AND THERAPY APGs

APC 1 Integumentary System

001 PHOTOCHEMOTHERAPY
002 SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
003 COMPLEX INCISION AND DRAINAGE
004 SIMPLE INCISION AND DRAINAGE
005 NAIL PROCEDURES
006 SIMPLE DEBRIDEMENT AND DESTRUCTION
007 COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
008 SIMPLE EXCISION AND BIOPSY
009 COMPLEX SKIN REPAIRS INCL INTEGUMENT GRAFTS, TRANSFER & REARRANGE
010 SIMPLE SKIN REPAIR
011 SIMPLE INCISION AND EXCISION OF BREAST
012 BREAST RECONSTRUCTION AND MASTECTOMY

APC 2 Musculoskeletal System

021 COMPLEX MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
022 SIMPLE MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
023 COMPLEX HAND AND FOOT MUSCULOSKELETAL PROCEDURES
024 SIMPLE HAND AND FOOT MUSCULOSKELETAL PROCEDURES
025 ARTHROSCOPY
026 REPLACEMENT OF CAST
027 SPLINT, STRAPPING AND CAST REMOVAL
028 CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK
029 CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK
030 OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES
031 BONE OR JOINT MANIPULATION UNDER ANESTHESIA
032 BUNION PROCEDURES
033 ARTHROPLASTY
034 HAND AND FOOT TENOTOMY
035 ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION

APC 3 Respiratory System

051 PULMONARY TESTS
052 NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION
053 COMPLEX ENDOSCOPY OF THE UPPER AIRWAY
054 SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
055 ENDOSCOPY OF THE LOWER AIRWAY
057 RESPIRATORY THERAPY

APC 4 Cardiovascular System

071 EXERCISE TOLERANCE TESTS
072 ECHOCARDIOGRAPHY
073 PHONOCARDIOGRAM
074 CARDIAC ELECTROPHYSIOLOGIC TESTS
075 PLACEMENT OF TRANSVENOUS CATHETERS
076 DIAGNOSTIC CARDIAC CATHETERIZATION
077 ANGIOPLASTY AND TRANSCATHETER PROCEDURES
078 PACEMAKER INSERTION AND REPLACEMENT
079 REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
080 MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
081 SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
082 VASCULAR LIGATION
083 RESUSCITATION AND CARDIOVERSION
084 CARDIAC REHABILITATION

APC 5 Hematologic, Lymphatic and Endocrine

091 CHEMOTHERAPY BY EXTENDED INFUSION
092 CHEMOTHERAPY EXCEPT BY EXTENDED INFUSION
093 PHLEBOTOMY
094 BLOOD AND BLOOD PRODUCT EXCHANGE
095 DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
096 ALLERGY TESTS
097 TRANSFUSION

APC 6 Digestive System

111 ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
112 ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
113 ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
114 PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
115 DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION
116 THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION
117 LOWER GASTROINTESTINAL ENDOSCOPY
118 ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES
119 HERNIA AND HYDROCELE PROCEDURES
120 COMPLEX ANAL AND RECTAL PROCEDURES
121 SIMPLE ANAL AND RECTAL PROCEDURES
122 MISCELLANEOUS ABDOMINAL PROCEDURES
123 COMPLEX LAPAROSCOPIC PROCEDURES
124 SIMPLE LAPAROSCOPIC PROCEDURES

APC 7 Urinary System

131 RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
132 SIMPLE URINARY STUDIES AND PROCEDURES
133 URINARY CATHETERIZATION AND DILATATION
134 COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAXY
135 MODERATE CYSTOURETHROSCOPY
136 SIMPLE CYSTOURETHROSCOPY
137 COMPLEX URETHRAL PROCEDURES
138 SIMPLE URETHRAL PROCEDURES
139 HEMODIALYSIS
140 PERITONEAL DIALYSIS

APC 8 Male Genital System

151 TESTICULAR AND EPIDIDYMAL PROCEDURES
152 INSERTION OF PENILE PROSTHESIS
153 COMPLEX PENILE PROCEDURES
154 SIMPLE PENILE PROCEDURES
155 PROSTATE NEEDLE AND PUNCH BIOPSY

APC 9 Female Genital System

171 ARTIFICIAL FERTILIZATION
172 PROCEDURES FOR PREGNANCY AND NEONATAL CARE
173 TREATMENT OF SPONTANEOUS ABORTION
174 THERAPEUTIC ABORTION
175 VAGINAL DELIVERY
176 COMPLEX FEMALE REPRODUCTIVE PROCEDURES
177 SIMPLE FEMALE REPRODUCTIVE PROCEDURES
178 DILATION AND CURETTAGE
179 HYSTEROSCOPY
180 COLPOSCOPY

APC 10 Nervous System

191 EXTENDED EEG STUDIES
192 ELECTROENCEPHALOGRAM
193 ELECTROCONVULSIVE THERAPY
194 NERVE AND MUSCLE TESTS
195 NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP
196 REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
197 NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
198 NERVE REPAIR AND DESTRUCTION
199 SPINAL TAP

APC 11 Eye and Ocular Adnexa

211 MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
212 FITTING OF CONTACT LENSES
213 LASER EYE PROCEDURES
214 CATARACT PROCEDURES
215 COMPLEX ANTERIOR SEGMENT EYE PROCEDURES
216 MODERATE ANTERIOR SEGMENT EYE PROCEDURES
217 SIMPLE ANTERIOR SEGMENT EYE PROCEDURES
218 COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
219 SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
220 STRABISMUS AND MUSCLE EYE PROCEDURES
221 COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE
222 SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
223 VITRECTOMY

APC 12 Facial, Ear, Nose, Mouth and Throat

231 COCHLEAR DEVICE IMPLANTATION
232 OTORHINOLARYNGOLOGIC FUNCTION TESTS
233 NASAL CAUTERIZATION AND PACKING
234 COMPLEX FACIAL AND ENT PROCEDURES
235 SIMPLE FACIAL AND ENT PROCEDURES
236 TONSIL AND ADENOID PROCEDURES
237 SIMPLE AUDIOMETRY

APC 13 Therapeutic and Other Significant Radiological Procedures

251 THERAPEUTIC NUCLEAR MEDICINE
252 RADIATION THERAPY AND HYPERTHERMIA
253 VASCULAR RADIOLOGY EXCEPT FOR VENOGRAPHY OF EXTREMITY
254 MYELOGRAPHY
255 MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST

APC 14 Physical Medicine and Rehabilitation

271 OCCUPATIONAL THERAPY
272 PHYSICAL THERAPY
273 SPEECH THERAPY

APC 15 Mental Illness and Substance Abuse Therapies

281 NEUROPSYCHOLOGICAL TESTING
282 FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
283 FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
284 HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE

285 HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
286 COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
287 INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY
288 FAMILY PSYCHOTHERAPY
289 GROUP PSYCHOTHERAPY

ANCILLARY SERVICES APGs

APC 16 Radiology

301 COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
302 INTERMEDIATE DIAGNOSTIC NUCLEAR MEDICINE
303 SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
304 OBSTETRICAL ULTRASOUND
305 DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
306 MAGNETIC RESONANCE IMAGING
307 COMPUTERIZED AXIAL TOMOGRAPHY
308 A MAMMOGRAPHY
309 DIGESTIVE RADIOLOGY
310 PLAIN FILM
311 THERAPEUTIC RADIATION TREATMENT PREPARATION

APC 17 Anesthesia

321 ANESTHESIA

APC 18 Pathology

331 COMPLEX PATHOLOGY
332 SIMPLE PATHOLOGY
333 PAP SMEARS

APC 19 Laboratory

341 BLOOD AND TISSUE TYPING
342 COMPLEX IMMUNOLOGY TESTS
343 SIMPLE IMMUNOLOGY TESTS
344 COMPLEX MICROBIOLOGY TESTS
345 SIMPLE MICROBIOLOGY TESTS
346 COMPLEX ENDOCRINOLOGY TESTS
347 SIMPLE ENDOCRINOLOGY TESTS
348 COMPLEX CHEMISTRY TESTS
349 SIMPLE CHEMISTRY TESTS
350 BASIC CHEMISTRY TESTS
351 MULTICHANNEL CHEMISTRY TESTS

352 ORGAN OR DISEASE ORIENTED PANELS
353 TOXICOLOGY TESTS
354 THERAPEUTIC DRUG MONITORING
355 COMPLEX CLOTTING TESTS
356 SIMPLE CLOTTING TESTS
357 COMPLEX HEMATOLOGY TESTS
358 SIMPLE HEMATOLOGY TESTS
359 URINALYSIS
360 BLOOD AND URINE DIPSTICK TESTS

APC 20 Other Ancillary Tests and Procedures

371 SIMPLE PULMONARY FUNCTION TESTS
372 INFUSION THERAPY EXCEPT CHEMOTHERAPY
373 CARDIOGRAM
374 COMPLEX IMMUNIZATION
375 MODERATE IMMUNIZATION
376 SIMPLE IMMUNIZATION AND ALLERGY IMMUNOTHERAPY
377 MINOR REPRODUCTIVE PROCEDURES
378 MINOR CARDIAC AND VASCULAR TESTS
379 MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
380 PACEMAKER ANALYSIS
381 TUBE CHANGE
382 PROVISION OF VISION AIDS
383 INTRODUCTION OF NEEDLE AND CATHETER
384 DRESSINGS AND OTHER MINOR PROCEDURES
385 OTHER MISCELANEOUS ANCILLARY PROCEDURES
386 BIOFEEDBACK AND OTHER TRAINING

APC 21 Chemotherapy Drugs

391 CLASS ONE CHEMOTHERAPY DRUGS
392 CLASS TWO CHEMOTHERAPY DRUGS
393 CLASS THREE CHEMOTHERAPY DRUGS
394 CLASS FOUR CHEMOTHERAPY DRUGS
395 CLASS FIVE CHEMOTHERAPY DRUGS

APC 22 Ancillary Mental Illness and Substance Abuse Services

411 PSYCHOTROPIC MEDICATION MANAGEMENT
412 ACTIVITY THERAPY

APC 23 Incidental Procedures and Services

421 INCIDENTAL TO MEDICAL, SIGNIFICANT PROCEDURE OR THERAPY VISIT
422 MEDICAL VISIT INDICATOR

MEDICAL APGs

APC 24 Malignancy

431 HEMATOLOGICAL MALIGNANCY
432 PROSTATIC MALIGNANCY
433 LUNG MALIGNANCY
434 BREAST MALIGNANCIES
435 GI MALIGNANCIES
436 SKIN MALIGNANCY
437 OTHER MALIGNANCIES

APC 25 Poisoning

451 POISONING

APC 26 Trauma

461 HEAD AND SPINE INJURY
462 MINOR SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
463 SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
464 FRACTURE, DISLOCATION AND SPRAIN
465 BURNS
466 OTHER INJURIES

APC 27 Neonate

481 NEONATE AND CONGENITAL ANOMALY

APC 28 Pregnancy

491 ROUTINE PRENATAL CARE
492 MATERNAL ANTEPARTUM COMPLICATION
493 ROUTINE POSTPARTUM CARE
494 MATERNAL POSTPARTUM COMPLICATION

APC 29 Infectious Diseases

501 COMPLEX INFECTIOUS DISEASE
502 MISCELLANEOUS INFECTIOUS DISEASES
503 INFECTIOUS DISEASES OF GENITAL ORGANS

APC 30 Nervous System Diseases

511 TIA, CVA AND OTHER CEREBROVASCULAR EVENTS
512 HEADACHE

513 EPILEPSY
514 NON TRAUMATIC LOSS OF CONSCIOUSNESS
515 OTHER DISEASES OF THE NERVOUS SYSTEM

APC 31 Eye Diseases

531 CATARACTS
532 REFRACTION DISORDER
533 CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION
534 EYE DISEASES EXCEPT CATARACT, REFRACTION DISORDER & CONJUNCTIVITIS

APC 32 Ear, Nose, Mouth and Throat Diseases

541 DENTAL DISEASE
542 INFLUENZA, URI AND ENT INFECTIONS
543 HEARING LOSS
544 OTHER COMPLEX EAR, NOSE, THROAT AND MOUTH DISEASES
545 OTHER SIMPLE EAR, NOSE, THROAT AND MOUTH DISEASES

APC 33 Respiratory System Diseases

561 EMPHYSEMA, CHRONIC BRONCHITIS, AND ASTHMA
562 PNEUMONIA
563 COMPLEX RESPIRATORY DIS EXC EMPHYSEMA, CHR BRONCHITIS & ASTHMA
564 SIMPLE RESPIRATORY DIS EXC EMPHYSEMA, CHR BRONCHITIS & ASTHMA

APC 34 Cardiovascular System Diseases

571 CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
572 HYPERTENSION
573 CHEST PAIN W CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
574 CHEST PAIN WO CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
575 SIMPLE CARDIOVASCULAR DIS EXC CHF, ISCHEMIC HEART DIS & HYPERTN
576 COMPLEX CARDIOVASCULAR DIS EXC CHF, ISCHEMIC HEART DIS & HYPERTN

APC 35 Digestive System Diseases

591 NONINFECTIOUS GASTROENTERITIS
592 ULCERS, GASTRITIS AND ESOPHAGITIS
593 HEPATOBILIARY DISEASE
594 HERNIA

595 HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
596 OTHER COMPLEX GASTROINTESTINAL DISEASES
597 OTHER SIMPLE GASTROINTESTINAL DISEASES

APC 36 Major Signs, Symptoms and Findings

611 MAJOR SIGNS, SYMPTOMS AND FINDINGS

APC 37 Musculoskeletal Diseases

621 BACK DISORDERS
622 COMPLEX MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
623 SIMPLE MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS

APC 38 Skin and Breast Diseases

631 DISEASE OF NAILS
632 CHRONIC SKIN ULCER
633 CELLULITIS, IMPETIGO AND LYMPHANGITIS
634 BREAST DISEASES
635 SKIN DISEASES

APC 39 Endocrine, Nutritional and Metabolic Diseases

651 DIABETES
652 COMPLEX ENDOCRINE,NUTRIT & METABOLIC DIS EXC DIABETES & OBESITY
653 SIMPLE ENDOCRINE, NUTRITIONAL & METABLIC DISEASE EXC DIABETES
654 FLUID AND ELECTROLYTE DISORDERS

APC 40 Kidney and Urinary Tract Diseases

661 URINARY TRACT INFECTION
662 RENAL FAILURE
663 COMPLEX URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
664 SIMPLE URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE

APC 41 Male Genital System Diseases

671 BENIGN PROSTATIC HYPERTROPHY
672 MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY

APC 42 Female Genital System Diseases

681 GYNECOLOGIC DISEASES

APC 43 Immunologic and Hematologic Diseases

691 HIV INFECTION
692 ANEMIA
693 OTHER COMPLEX IMMUNOLOGIC AND HEMATOLOGIC DISEASE
694 OTHER SIMPLE IMMUNOLOGIC AND HEMATOLOGIC DISEASE

APC 44 Well Care, Administrative

701 ADULT MEDICAL EXAMINATION
702 WELL CHILD CARE
703 CONTRACEPTION AND PROCREATIVE MANAGEMENT
704 AFTERCARE
705 NONSPECIFIC SIGNS & SYMPTOMS & OTH CONTACTS W HEALTH SVCS

APC 45 Unknown Cause of Mortality

721 UNKNOWN CAUSE OF MORTALITY

APC 46 Error

992 INVALID PROCEDURE CODE
993 INPATIENT PROCEDURE
994 AUTOPSY SERVICES
995 NON COVERED CARE SETTINGS AND SERVICES
996 INVALID RVDX CODE
997 ECODE CANNOT BE USED AS RVDX
998 UNACCEPTABLE RVDX, REQUIRES PROCEDURE
999 UNGROUPABLE

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APPENDIX M

Six Sets of Relative Weights

Relative Weights Based on Cost with Full Packaging

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
001	S	1120	98.68	0.431	1.119	97.62	2.38	PHOTOCHEMOTHERAPY
002	S	7518	99.99	3.768	0.975	75.16	24.84	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
003	S	597	100.00	5.055	1.064	87.93	12.07	COMPLEX INCISION AND DRAINAGE
004	S	3091	100.00	2.757	1.308	85.76	14.24	SIMPLE INCISION AND DRAINAGE
005	S	1612	99.44	0.679	1.277	95.22	4.78	NAIL PROCEDURES
006	S	11392	100.00	3.052	1.480	90.30	9.70	SIMPLE DEBRIDEMENT AND DESTRUCTION
007	S	12944	100.00	6.424	0.870	87.18	12.82	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
008	S	29900	100.00	5.009	0.940	86.13	13.87	SIMPLE EXCISION AND BIOPSY
009	S	3915	100.00	9.375	0.695	89.21	10.79	COMPLEX SKIN REPAIRS INCL INTEGUMENT GRAFTS, TRANSFER & REARRANGE
010	S	23059	99.41	1.992	0.727	77.65	22.35	SIMPLE SKIN REPAIR
011	S	12620	100.00	8.309	0.685	84.27	15.73	SIMPLE INCISION AND EXCISION OF BREAST
012	S	1154	100.00	12.345	0.569	85.98	14.02	BREAST RECONSTRUCTION AND MASTECTOMY
021	S	1294	100.00	15.132	0.586	88.90	11.10	COMPLEX MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT.
022	S	1685	100.00	9.730	0.643	87.19	12.81	SIMPLE MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
023	S	2261	100.00	12.956	0.553	88.44	11.56	COMPLEX HAND AND FOOT MUSCULOSKELETAL PROCEDURES
024	S	11802	99.98	9.456	0.620	88.68	11.32	SIMPLE HAND AND FOOT MUSCULOSKELETAL PROCEDURES
025	S	6170	99.85	16.180	0.419	90.52	9.48	ARTHROSCOPY
026	S	1499	99.60	2.170	0.680	77.61	22.39	REPLACEMENT OF CAST
027	S	4268	99.81	1.602	0.745	70.95	29.05	SPLINT, STRAPPING AND CAST REMOVAL
028	S	1383	99.00	2.466	0.618	58.91	41.09	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK
029	S	6095	99.36	3.544	1.076	69.99	30.01	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK
030	S	983	100.00	14.126	0.712	85.27	14.73	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES
031	S	606	100.00	7.663	0.719	82.04	17.96	BONE OR JOINT MANIPULATION UNDER ANESTHESIA
032	S	2173	99.91	15.049	0.501	88.40	11.60	BUNION PROCEDURES
033	S	522	99.81	16.671	0.552	90.88	9.12	ARTHROPLASTY
034	S	250	100.00	8.186	0.655	89.54	10.46	HAND AND FOOT TENOTOMY
035	S	4558	99.61	1.728	1.049	84.41	15.59	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION
051	S	88916	99.99	3.015	0.992	63.50	36.50	PULMONARY TESTS
052	S	4729	99.66	3.219	0.776	72.99	27.01	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION

Relative Weights Based on Cost with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
053	S	2704	99.96	12.127	0.485	84.87	15.13	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY
054	S	1751	100.00	4.649	1.154	85.74	14.26	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
055	S	8766	99.91	7.258	0.582	75.67	24.33	ENDOSCOPY OF THE LOWER AIRWAY
057	S	44616	99.99	3.007	0.988	65.23	34.77	RESPIRATORY THERAPY
071	S	106033	99.85	1.701	0.750	94.43	5.57	EXERCISE TOLERANCE TESTS
072	S	48005	99.72	2.181	0.910	90.20	9.80	ECHOCARDIOGRAPHY
073	S	1186	99.92	2.026	0.962	64.15	35.85	PHONOCARDIOGRAM
074	S	376	100.00	15.485	0.748	94.89	5.11	CARDIAC ELECTROPHYSIOLOGIC TESTS
075	S	3156	99.97	9.858	0.820	87.26	12.74	PLACEMENT OF TRANSVENOUS CATHETERS.
076	S	17133	99.99	20.820	0.460	96.18	3.82	DIAGNOSTIC CARDIAC CATHETERIZATION
077	S	552	100.00	13.546	0.806	93.90	6.10	ANGIOPLASTY AND TRANSCATHETER PROCEDURES
078	S	1095	100.00	51.219	0.558	96.78	3.22	PACEMAKER INSERTION AND REPLACEMENT
079	S	1132	99.91	8.574	1.290	90.52	9.48	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
080	S	7075	100.00	15.476	0.571	90.62	9.38	MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
081	S	385	100.00	7.059	0.963	92.09	7.91	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
082	S	362	100.00	13.497	0.634	89.53	10.47	VASCULAR LIGATION
083	S	3737	99.97	5.219	1.010	89.99	10.01	RESUSCITATION AND CARDIOVERSION
084	S	6778	99.54	1.136	1.467	97.41	2.59	CARDIAC REHABILITATION
091	S	2425	99.96	2.056	1.301	87.97	12.03	CHEMOTHERAPY BY EXTENDED INFUSION
092	S	2570	99.96	2.781	1.111	95.56	4.44	CHEMOTHERAPY EXCEPT BY EXTENDED INFUSION
093	S	3938	99.39	0.860	1.519	67.16	32.84	PHLEBOTOMY
094	S	557	100.00	9.156	0.735	96.05	3.95	BLOOD AND BLOOD PRODUCT EXCHANGE
095	S	2676	100.00	9.849	0.643	84.21	15.79	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
096	S	1428	100.00	2.046	0.959	74.13	25.87	ALLERGY TESTS
097	S	13824	99.88	4.737	0.706	94.81	5.19	TRANSFUSION
111	S	4086	100.00	2.744	0.800	88.53	11.47	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
112	S	4903	99.98	3.037	0.798	94.53	5.47	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
113	S	29633	99.51	2.054	0.826	94.10	5.90	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
114	S	5847	99.78	3.785	0.816	88.68	11.32	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
115	S	67207	99.75	4.354	0.598	92.00	8.00	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION
116	S	11159	99.94	5.174	0.716	93.22	6.78	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION
117	S	118377	99.75	5.100	0.553	92.80	7.20	LOWER GASTROINTESTINAL ENDOSCOPY
118	S	1397	100.00	7.044	0.798	88.92	11.08	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES

Relative Weights Based on Cost with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
119	S	15437	99.83	14.629	0.456	89.46	10.54	HERNIA AND HYDROCELE PROCEDURES
120	S	1597	100.00	11.293	0.559	87.96	12.04	COMPLEX ANAL AND RECTAL PROCEDURES
121	S	1325	100.00	5.540	1.117	88.24	11.76	SIMPLE ANAL AND RECTAL PROCEDURES
122	S	976	100.00	8.092	0.817	90.49	9.51	MISCELLANEOUS ABDOMINAL PROCEDURES
123	S	1250	99.92	29.203	0.350	91.60	8.40	COMPLEX LAPAROSCOPIC PROCEDURES
124	S	458	100.00	16.267	0.508	88.86	11.14	SIMPLE LAPAROSCOPIC PROCEDURES
131	S	2477	100.00	39.272	0.455	97.29	2.71	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
132	S	2295	100.00	3.344	0.828	94.99	5.01	SIMPLE URINARY STUDIES AND PROCEDURES
133	S	7485	99.49	2.016	1.091	81.03	18.97	URINARY CATHETERIZATION AND DILATATION
134	S	5633	99.98	11.742	0.735	87.60	12.40	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAXY
135	S	8294	99.96	9.139	0.646	86.62	13.38	MODERATE CYSTOURETHROSCOPY
136	S	24603	99.90	4.812	0.769	90.46	9.54	SIMPLE CYSTOURETHROSCOPY
137	S	291	100.00	13.949	0.576	88.18	11.82	COMPLEX URETHRAL PROCEDURES
138	S	172	100.00	8.792	0.615	87.98	12.02	SIMPLE URETHRAL PROCEDURES
139	S	166	100.00	6.858	1.039	88.25	11.75	HEMODIALYSIS
140	S	37	100.00	2.609	0.846	98.42	1.58	PERITONEAL DIALYSIS
151	S	2733	100.00	11.647	0.443	87.16	12.84	TESTICULAR AND EPIDIDYMAL PROCEDURES
152	S	317	100.00	44.078	0.342	96.13	3.87	INSERTION OF PENILE PROSTHESIS
153	S	131	100.00	27.575	0.787	93.69	6.31	COMPLEX PENILE PROCEDURES
154	S	1371	99.85	8.992	0.569	87.87	12.13	SIMPLE PENILE PROCEDURES
155	S	5849	99.97	4.834	0.874	83.48	16.52	PROSTATE NEEDLE AND PUNCH BIOPSY
171	S	8	100.00	2.365	0.829	87.19	12.81	ARTIFICIAL FERTILIZATION
172	S	152	100.00	1.587	0.930	89.86	10.14	PROCEDURES FOR PREGNANCY AND NEONATAL CARE
173	S	42	100.00	10.108	0.425	86.86	13.14	TREATMENT OF SPONTANEOUS ABORTION
174	S	12	100.00	7.914	0.476	86.46	13.54	THERAPEUTIC ABORTION
175	S	1	100.00	1.401	0.000	88.47	11.53	VAGINAL DELIVERY
176	S	142	100.00	13.775	0.657	87.10	12.90	COMPLEX FEMALE REPRODUCTIVE PROCEDURES
177	S	1768	100.00	9.051	0.617	85.08	14.92	SIMPLE FEMALE REPRODUCTIVE PROCEDURES
178	S	4347	99.86	9.637	0.431	82.85	17.15	DILATION AND CURETTAGE
179	S	334	100.00	11.082	0.443	85.84	14.16	HYSTEROSCOPY
180	S	378	100.00	4.131	1.166	85.45	14.55	COLPOSCOPY
191	S	2986	99.97	6.354	0.570	99.03	0.97	EXTENDED EEG STUDIES
192	S	23776	99.12	1.779	0.827	93.23	6.77	ELECTROENCEPHALOGRAM
193	S	1544	99.94	2.703	0.723	90.29	9.71	ELECTROCONVULSIVE THERAPY

Relative Weights Based on Cost with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
194	S	9264	99.77	1.285	0.993	93.40	6.60	NERVE AND MUSCLE TESTS
195	S	32870	99.73	2.597	0.807	93.98	6.02	NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP
196	S	72	100.00	21.227	1.201	94.23	5.77	REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
197	S	79	100.00	39.583	1.093	96.23	3.77	NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
198	S	11445	99.93	9.396	0.521	89.55	10.45	NERVE REPAIR AND DESTRUCTION
199	S	679	99.85	3.427	0.695	68.66	31.34	SPINAL TAP
211	S	10981	99.93	1.433	0.683	98.12	1.88	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
212	S	9	100.00	1.559	0.621	97.85	2.15	FITTING OF CONTACT LENSES
213	S	76275	99.57	3.128	0.609	99.78	0.22	LASER EYE PROCEDURES
214	S	158640	99.83	16.796	0.403	94.83	5.17	CATARACT PROCEDURES
215	S	1043	100.00	22.964	0.453	93.07	6.93	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES
216	S	4944	100.00	10.835	0.654	92.89	7.11	MODERATE ANTERIOR SEGMENT EYE PROCEDURES
217	S	3357	100.00	6.318	0.905	94.72	5.28	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES
218	S	1242	100.00	17.564	0.763	92.62	7.38	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
219	S	1264	100.00	6.366	1.294	94.06	5.94	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
220	S	469	100.00	11.444	0.484	89.79	10.21	STRABISMUS AND MUSCLE EYE PROCEDURES
221	S	4039	99.98	11.757	0.591	90.36	9.64	COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE
222	S	4762	100.00	6.971	0.848	91.06	8.94	SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
223	S	1423	99.86	19.958	0.487	94.07	5.93	VITRECTOMY
231	S	3	100.00	73.024	0.677	96.33	3.67	COCHLEAR DEVICE IMPLANTATION
232	S	1701	99.71	1.881	0.733	91.22	8.78	OTORHINOLARYNGOLOGIC FUNCTION TESTS
233	S	3491	99.15	1.687	0.823	88.87	11.13	NASAL CAUTERIZATION AND PACKING
234	S	3104	100.00	13.809	0.589	88.42	11.58	COMPLEX FACIAL AND ENT PROCEDURES
235	S	6979	99.99	6.131	0.985	85.89	14.11	SIMPLE FACIAL AND ENT PROCEDURES
236	S	87	98.86	11.504	0.499	85.48	14.52	TONSIL AND ADENOID PROCEDURES
237	S	6809	99.45	1.105	0.739	97.66	2.34	SIMPLE AUDIOMETRY
251	S	2185	100.00	2.945	0.865	95.61	4.39	THERAPEUTIC NUCLEAR MEDICINE
252	S	28509	98.18	1.857	0.982	95.73	4.27	RADIATION THERAPY AND HYPERTHERMIA
253	S	12522	100.00	10.459	0.663	93.91	6.09	VASCULAR RADIOLOGY EXCEPT FOR VENOGRAPHY OF EXTREMITY
254	S	8370	99.84	5.583	0.544	89.69	10.31	MYELOGRAPHY
255	S	93438	99.52	2.137	0.604	89.71	10.29	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
271	S	5838	99.42	1.081	0.965	96.95	3.05	OCCUPATIONAL THERAPY
272	S	40819	99.18	1.304	1.263	91.04	8.96	PHYSICAL THERAPY
273	S	3773	99.32	1.219	1.014	94.13	5.87	SPEECH THERAPY

Relative Weights Based on Cost with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
281	S	1123	100.00	3.699	1.215	98.62	1.38	NEUROPSYCHOLOGICAL TESTING
282	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
283	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
284	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
285	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
286	S	101119	99.85	1.476	1.038	80.83	19.17	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
287	S	24432	99.81	1.325	0.956	95.60	4.40	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY
288	S	579	100.00	1.071	0.806	97.71	2.29	FAMILY PSYCHOTHERAPY
289	S	4125	99.37	1.083	1.323	99.13	0.87	GROUP PSYCHOTHERAPY
301	A	94567	99.97	4.038	0.497			COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
302	A	142803	99.85	2.521	0.446			INTERMEDIATE DIAGNOSTIC NUCLEAR MEDICINE
303	A	79341	99.90	1.764	0.672			SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
304	A	2637	99.96	1.165	0.555			OBSTETRICAL ULTRASOUND
305	A	379953	99.84	1.328	0.550			DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
306	A	88256	99.88	5.734	0.357			MAGNETIC RESONANCE IMAGING
307	A	535153	99.95	2.960	0.462			COMPUTERIZED AXIAL TOMOGRAPHY
308	A	488216	99.80	0.521	0.516			MAMMOGRAPHY
309	A	294355	99.78	1.175	0.401			DIGESTIVE RADIOLOGY
310	A	2647171	99.48	0.557	0.481			PLAIN FILM
311	A	25541	99.81	1.715	0.980			THERAPEUTIC RADIATION TREATMENT PREPARATION
321	A	325767	99.97	0.874	1.106			ANESTHESIA
331	A	46252	99.79	0.621	1.056			COMPLEX PATHOLOGY
332	A	645170	99.77	0.331	1.007			SIMPLE PATHOLOGY
333	A	130606	99.69	0.085	0.594			PAP SMEARS
341	A	115322	99.84	0.339	1.136			BLOOD AND TISSUE TYPING
342	A	72848	99.32	0.300	0.923			COMPLEX IMMUNOLOGY TESTS
343	A	221774	99.76	0.154	0.826			SIMPLE IMMUNOLOGY TESTS
344	A	147466	99.94	0.286	0.814			COMPLEX MICROBIOLOGY TESTS
345	A	889172	99.81	0.165	0.715			SIMPLE MICROBIOLOGY TESTS
346	A	103913	99.38	0.304	0.802			COMPLEX ENDOCRINOLOGY TESTS
347	A	684027	99.93	0.188	0.690			SIMPLE ENDOCRINOLOGY TESTS
348	A	949642	99.82	0.218	0.612			COMPLEX CHEMISTRY TESTS
349	A	1299622	99.80	0.169	0.913			SIMPLE CHEMISTRY TESTS
350	A	1493036	99.61	0.096	0.710			BASIC CHEMISTRY TESTS

Relative Weights Based on Cost with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
351	A	2844021	99.96	0.251	0.824			MULTICHANNEL CHEMISTRY TESTS
352	A	530753	99.79	0.280	0.652			ORGAN OR DISEASE ORIENTED PANELS
353	A	39340	99.68	0.256	0.780			TOXICOLOGY TESTS
354	A	344532	99.78	0.237	0.571			THERAPEUTIC DRUG MONITORING
355	A	12236	99.28	0.198	1.042			COMPLEX CLOTTING TESTS
356	A	1324932	99.88	0.096	0.632			SIMPLE CLOTTING TESTS
357	A	1789	99.06	0.129	0.850			COMPLEX HEMATOLOGY TESTS
358	A	3780586	99.92	0.106	0.685			SIMPLE HEMATOLOGY TESTS
359	A	978410	99.92	0.081	0.645			URINALYSIS
360	A	144135	99.83	0.069	0.687			BLOOD AND URINE DIPSTICK TESTS
371	A	147924	99.96	0.494	1.066			SIMPLE PULMONARY FUNCTION TESTS
372	A	146274	99.81	0.222	1.329			INFUSION THERAPY EXCEPT CHEMOTHERAPY
373	A	886603	99.29	0.274	0.657			CARDIOGRAM
374	A	117	100.00	1.605	1.674			COMPLEX IMMUNIZATION
375	A	34	100.00	0.486	0.620			MODERATE IMMUNIZATION
376	A	2583	100.00	0.355	1.831			SIMPLE IMMUNIZATION AND ALLERGY IMMUNOTHERAPY.
377	A	329	99.70	1.341	1.634			MINOR REPRODUCTIVE PROCEDURES
378	A	149560	99.97	1.185	0.743			MINOR CARDIAC AND VASCULAR TESTS
379	A	1453	99.45	1.129	1.082			MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
380	A	54643	99.38	0.283	0.602			PACEMAKER ANALYSIS
381	A	5174	99.98	1.936	1.055			TUBE CHANGE
382	A	522	100.00	2.282	0.763			PROVISION OF VISION AIDS
383	A	2100985	99.19	0.032	0.736			INTRODUCTION OF NEEDLE AND CATHETER
384	A	1602	99.63	0.577	1.007			DRESSINGS AND OTHER MINOR PROCEDURES
385	A	2837	100.00	1.392	1.415			OTHER MISCELANEOUS ANCILLARY PROCEDURES
386	A	130	97.74	0.579	1.105			BIOFEEDBACK AND OTHER TRAINING
391	A	5481	99.95	0.751	2.275			CLASS ONE CHEMOTHERAPY DRUGS
392	A	853	99.30	0.646	1.410			CLASS TWO CHEMOTHERAPY DRUGS
393	A	974	100.00	2.016	1.182			CLASS THREE CHEMOTHERAPY DRUGS
394	A	499	99.60	2.033	0.755			CLASS FOUR CHEMOTHERAPY DRUGS
395	A	312	100.00	4.070	0.606			CLASS FIVE CHEMOTHERAPY DRUGS
411	A	1210	99.34	0.607	0.826			PSYCHOTROPIC MEDICATION MANAGEMENT
412	A	88	98.88	1.143	1.479			ACTIVITY THERAPY
431	M	15518	99.95	1.790	1.442	80.17	19.83	HEMATOLOGICAL MALIGNANCY

Relative Weights Based on Cost with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
432	M	16111	99.91	0.966	1.326	84.26	15.74	PROSTATIC MALIGNANCY
433	M	9056	99.86	1.630	1.321	70.97	29.03	LUNG MALIGNANCY
434	M	15669	99.76	0.981	1.235	71.08	28.92	BREAST MALIGNANCIES
435	M	12051	99.89	1.328	1.247	74.58	25.42	GI MALIGNANCIES
436	M	6679	99.75	0.866	1.213	79.21	20.79	SKIN MALIGNANCY
437	M	26301	99.87	1.214	1.425	78.81	21.19	OTHER MALIGNANCIES
451	M	8994	99.93	1.900	1.005	73.16	26.84	POISONING
461	M	9130	99.95	2.501	0.870	55.13	44.87	HEAD AND SPINE INJURY
462	M	59447	99.93	1.419	0.736	72.64	27.36	MINOR SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
463	M	81436	99.92	1.988	0.728	57.07	42.93	SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
464	M	124945	99.92	1.958	0.704	57.69	42.31	FRACTURE, DISLOCATION AND SPRAIN
465	M	5070	99.71	1.069	0.844	93.04	6.96	BURNS
466	M	14469	99.77	1.518	0.964	78.08	21.92	OTHER INJURIES
481	M	175	100.00	1.239	0.877	64.37	35.63	NEONATE AND CONGENITAL ANOMALY
491	M	762	99.87	1.190	0.878	87.55	12.45	ROUTINE PRENATAL CARE
492	M	566	99.82	1.695	0.904	85.30	14.70	MATERNAL ANTEPARTUM COMPLICATION
493	M	73	98.65	1.163	0.931	90.04	9.96	ROUTINE POSTPARTUM CARE
494	M	175	100.00	1.634	1.142	79.42	20.58	MATERNAL POSTPARTUM COMPLICATION
501	M	4567	99.89	2.666	0.866	59.06	40.94	COMPLEX INFECTIOUS DISEASE
502	M	13594	99.91	1.664	0.884	64.83	35.17	MISCELLANEOUS INFECTIOUS DISEASES
503	M	4672	99.98	1.146	0.794	78.56	21.44	INFECTIOUS DISEASES OF GENITAL ORGANS
511	M	19203	99.99	2.214	1.104	67.98	32.02	TIA, CVA AND OTHER CEREBROVASCULAR EVENTS
512	M	31945	99.79	1.175	0.909	80.76	19.24	HEADACHE
513	M	4550	99.96	1.478	1.092	78.01	21.99	EPILEPSY
514	M	32662	99.98	2.500	0.907	66.38	33.62	NON TRAUMATIC LOSS OF CONSCIOUSNESS
515	M	34889	99.84	1.193	1.178	77.91	22.09	OTHER DISEASES OF THE NERVOUS SYSTEM
531	M	22535	99.88	0.802	1.272	92.42	7.58	CATARACTS
532	M	2875	99.83	0.700	0.762	98.67	1.33	REFRACTION DISORDER
533	M	10461	99.79	0.796	0.827	93.71	6.29	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION
534	M	83361	99.84	0.792	1.007	95.85	4.15	EYE DISEASES EXCEPT CATARACT,REFRACTION DISORDER & CONJUNCTIVITIS
541	M	2896	99.59	0.845	0.852	87.25	12.75	DENTAL DISEASE
542	M	57388	99.93	1.033	0.978	71.40	28.60	INFLUENZA, URI AND ENT INFECTIONS.

Relative Weights Based on Cost with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
543	M	4333	99.88	0.825	1.011	93.81	6.19	HEARING LOSS
544	M	26171	99.80	1.540	0.858	77.95	22.05	OTHER COMPLEX EAR, NOSE, THROAT AND MOUTH DISEASES
545	M	30495	99.91	0.925	1.060	81.13	18.87	OTHER SIMPLE EAR, NOSE, THROAT AND MOUTH DISEASES
561	M	81636	99.94	1.516	0.960	62.30	37.70	EMPHYSEMA, CHRONIC BRONCHITIS, AND ASTHMA.
562	M	14692	99.93	2.182	0.795	56.39	43.61	PNEUMONIA
563	M	17734	99.98	2.467	0.858	58.83	41.17	COMPLEX RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
564	M	7477	99.97	2.005	0.873	57.10	42.90	SIMPLE RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
571	M	29495	99.97	2.286	1.253	64.57	35.43	CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
572	M	128040	99.84	0.971	0.993	79.06	20.94	HYPERTENSION
573	M	17096	99.45	3.727	0.594	53.80	46.20	CHEST PAIN W CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
574	M	53657	99.98	2.216	0.855	61.42	38.58	CHEST PAIN WO CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
575	M	69432	99.90	1.297	1.232	72.28	27.72	SIMPLE CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
576	M	24735	99.91	2.250	1.150	69.90	30.10	COMPLEX CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
591	M	23713	99.92	2.263	0.888	60.60	39.40	NONINFECTIOUS GASTROENTERITIS
592	M	31795	99.98	1.901	0.964	63.65	36.35	ULCERS, GASTRITIS AND ESOPHAGITIS
593	M	10227	99.96	2.025	1.108	63.22	36.78	HEPATOBILIARY DISEASE
594	M	8151	99.98	1.375	1.089	67.70	32.30	HERNIA
595	M	9686	99.86	1.371	1.003	75.67	24.33	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
596	M	6929	99.96	2.356	1.085	64.02	35.98	OTHER COMPLEX GASTROINTESTINAL DISEASES
597	M	108093	99.96	2.034	0.909	60.79	39.21	OTHER SIMPLE GASTROINTESTINAL DISEASES
611	M	15605	99.98	4.123	0.933	86.02	13.98	MAJOR SIGNS, SYMPTOMS AND FINDINGS
621	M	44321	99.93	1.497	0.946	63.02	36.98	BACK DISORDERS
622	M	28805	99.82	1.535	0.925	60.76	39.24	COMPLEX MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
623	M	132005	99.95	1.250	0.922	65.10	34.90	SIMPLE MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
631	M	8465	99.86	0.645	0.892	95.81	4.19	DISEASE OF NAILS
632	M	11609	99.59	1.081	1.059	86.28	13.72	CHRONIC SKIN ULCER
633	M	18473	99.82	1.203	0.913	77.31	22.69	CELLULITIS, IMPETIGO AND LYMPHANGITIS

Relative Weights Based on Cost with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
634	M	6601	99.91	0.838	1.022	82.26	17.74	BREAST DISEASES
635	M	59801	99.86	0.850	0.940	87.11	12.89	SKIN DISEASES
651	M	61701	99.75	0.986	0.999	80.00	20.00	DIABETES
652	M	9920	99.84	2.316	0.887	70.01	29.99	COMPLEX ENDOCRINE,NUTRIT & METABOLIC DIS EXC DIABETES & OBESITY
653	M	21151	99.85	0.847	0.988	77.13	22.87	SIMPLE ENDOCRINE, NUTRITIONAL & METABLIC DISEASE EXC DIABETES
654	M	9322	99.88	3.310	0.893	65.46	34.54	FLUID AND ELECTROLYTE DISORDERS
661	M	42428	99.94	1.832	0.837	58.52	41.48	URINARY TRACT INFECTION
662	M	7743	99.94	1.747	0.982	68.18	31.82	RENAL FAILURE
663	M	31591	99.81	1.570	0.862	72.61	27.39	COMPLEX URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
664	M	19428	99.83	1.152	0.981	78.22	21.78	SIMPLE URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
671	M	9762	99.84	0.697	1.191	76.19	23.81	BENIGN PROSTATIC HYPERTROPHY
672	M	7716	99.88	0.977	0.996	76.24	23.76	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY
681	M	14967	99.88	1.063	0.959	80.73	19.27	GYNECOLOGIC DISEASES
691	M	1967	99.95	1.635	1.041	79.80	20.20	HIV INFECTION
692	M	16128	100.00	2.584	1.051	86.11	13.89	ANEMIA
693	M	5471	99.84	2.786	1.393	88.31	11.69	OTHER COMPLEX IMMUNOLOGIC AND HEMATOLOGIC DISEASE
694	M	11308	99.77	1.466	1.403	80.24	19.76	OTHER SIMPLE IMMUNOLOGIC AND HEMATOLOGIC DISEASE
701	M	4233	99.79	1.042	0.984	78.02	21.98	ADULT MEDICAL EXAMINATION
702	M	3	100.00	1.189	1.141	76.02	23.98	WELL CHILD CARE
703	M	215	99.54	0.684	0.827	92.92	7.08	CONTRACEPTION AND PROCREATIVE MANAGEMENT
704	M	43499	99.74	0.630	1.019	83.25	16.75	AFTERCARE
705	M	102944	99.95	1.662	1.109	67.83	32.17	NONSPECIFIC SIGNS & SYMPTOMS & OTH CONTACTS W HEALTH SVCS
721	M	1357	100.00	2.106	1.210	86.38	13.62	UNKNOWN CAUSE OF MORTALITY.

Relative Weights Based on Cost with Simple Packaging

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
001	S	1120	98.68	0.428	1.109	97.77	2.23	PHOTOCHEMOTHERAPY
002	S	7518	99.99	3.747	0.974	75.26	24.74	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
003	S	597	100.00	5.028	1.064	88.02	11.98	COMPLEX INCISION AND DRAINAGE
004	S	3091	100.00	2.744	1.307	85.80	14.20	SIMPLE INCISION AND DRAINAGE
005	S	1612	99.44	0.677	1.277	95.22	4.78	NAIL PROCEDURES
006	S	11392	100.00	3.037	1.480	90.38	9.62	SIMPLE DEBRIDEMENT AND DESTRUCTION
007	S	12944	100.00	6.394	0.870	87.22	12.78	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
008	S	29900	100.00	4.986	0.939	86.16	13.84	SIMPLE EXCISION AND BIOPSY
009	S	3915	100.00	9.332	0.695	89.24	10.76	COMPLEX SKIN REPAIRS INCL INTEGUMENT GRAFTS, TRANSFER & REARRANGE
010	S	23059	99.41	1.984	0.728	77.66	22.34	SIMPLE SKIN REPAIR
011	S	12620	100.00	8.269	0.685	84.32	15.68	SIMPLE INCISION AND EXCISION OF BREAST
012	S	1154	100.00	12.278	0.569	86.08	13.92	BREAST RECONSTRUCTION AND MASTECTOMY
021	S	1294	100.00	15.057	0.586	88.96	11.04	COMPLEX MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT.
022	S	1685	100.00	9.684	0.643	87.24	12.76	SIMPLE MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
023	S	2261	100.00	12.895	0.553	88.48	11.52	COMPLEX HAND AND FOOT MUSCULOSKELETAL PROCEDURES
024	S	11802	99.98	9.411	0.620	88.72	11.28	SIMPLE HAND AND FOOT MUSCULOSKELETAL PROCEDURES
025	S	6170	99.85	16.103	0.419	90.56	9.44	ARTHROSCOPY
026	S	1499	99.60	2.160	0.680	77.64	22.36	REPLACEMENT OF CAST
027	S	4268	99.81	1.595	0.745	70.97	29.03	SPLINT, STRAPPING AND CAST REMOVAL
028	S	1383	99.00	2.456	0.618	58.92	41.08	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK
029	S	6095	99.36	3.528	1.075	70.01	29.99	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK
030	S	983	100.00	14.056	0.712	85.33	14.67	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES
031	S	606	100.00	7.622	0.720	82.13	17.87	BONE OR JOINT MANIPULATION UNDER ANESTHESIA
032	S	2173	99.91	14.980	0.501	88.44	11.56	BUNION PROCEDURES
033	S	522	99.81	16.592	0.552	90.92	9.08	ARTHROPLASTY
034	S	250	100.00	8.148	0.655	89.57	10.43	HAND AND FOOT TENOTOMY
035	S	4558	99.61	1.720	1.048	84.46	15.54	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION
051	S	88918	99.99	2.862	1.053	66.66	33.34	PULMONARY TESTS
052	S	4730	99.68	3.202	0.778	73.10	26.90	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION

Relative Weights Based on Cost with Simple Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
053	S	2704	99.96	12.058	0.485	84.99	15.01	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY
054	S	1751	100.00	4.619	1.155	85.94	14.06	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
055	S	8766	99.91	7.172	0.585	76.26	23.74	ENDOSCOPY OF THE LOWER AIRWAY
057	S	44619	100.00	2.921	1.023	66.97	33.03	RESPIRATORY THERAPY
071	S	106032	99.85	1.687	0.748	94.78	5.22	EXERCISE TOLERANCE TESTS
072	S	48004	99.72	2.156	0.911	90.83	9.17	ECHOCARDIOGRAPHY
073	S	1186	99.92	2.012	0.962	64.32	35.68	PHONOCARDIOGRAM
074	S	376	100.00	15.372	0.752	95.19	4.81	CARDIAC ELECTROPHYSIOLOGIC TESTS
075	S	3156	99.97	9.811	0.821	87.30	12.70	PLACEMENT OF TRANSVENOUS CATHETERS.
076	S	17133	99.99	20.728	0.461	96.20	3.80	DIAGNOSTIC CARDIAC CATHETERIZATION
077	S	552	100.00	13.485	0.807	93.93	6.07	ANGIOPLASTY AND TRANSCATHETER PROCEDURES
078	S	1095	100.00	50.994	0.558	96.79	3.21	PACEMAKER INSERTION AND REPLACEMENT
079	S	1132	99.91	8.522	1.289	90.69	9.31	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
080	S	7075	100.00	15.403	0.570	90.67	9.33	MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
081	S	385	100.00	7.028	0.962	92.11	7.89	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
082	S	362	100.00	13.434	0.634	89.57	10.43	VASCULAR LIGATION
083	S	3737	99.97	5.165	1.013	90.56	9.44	RESUSCITATION AND CARDIOVERSION
084	S	6778	99.54	1.128	1.467	97.71	2.29	CARDIAC REHABILITATION
091	S	2425	99.96	2.047	1.301	87.98	12.02	CHEMOTHERAPY BY EXTENDED INFUSION
092	S	2570	99.96	2.768	1.111	95.59	4.41	CHEMOTHERAPY EXCEPT BY EXTENDED INFUSION
093	S	3938	99.39	0.853	1.521	67.38	32.62	PHLEBOTOMY
094	S	557	100.00	9.116	0.735	96.07	3.93	BLOOD AND BLOOD PRODUCT EXCHANGE
095	S	2676	100.00	9.801	0.642	84.27	15.73	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
096	S	1428	100.00	2.007	0.966	75.21	24.79	ALLERGY TESTS
097	S	13824	99.88	4.715	0.706	94.85	5.15	TRANSFUSION
111	S	4086	100.00	2.729	0.800	88.65	11.35	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
112	S	4902	99.96	3.016	0.792	94.61	5.39	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
113	S	29633	99.51	2.044	0.826	94.16	5.84	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
114	S	5847	99.78	3.766	0.817	88.75	11.25	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
115	S	67208	99.75	4.334	0.598	92.06	7.94	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION
116	S	11159	99.94	5.148	0.716	93.30	6.70	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION
117	S	118378	99.75	5.076	0.553	92.85	7.15	LOWER GASTROINTESTINAL ENDOSCOPY
118	S	1397	100.00	7.011	0.798	88.96	11.04	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES

Relative Weights Based on Cost with Simple Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
119	S	15437	99.83	14.555	0.456	89.54	10.46	HERNIA AND HYDROCELE PROCEDURES
120	S	1597	100.00	11.237	0.559	88.03	11.97	COMPLEX ANAL AND RECTAL PROCEDURES
121	S	1325	100.00	5.514	1.117	88.29	11.71	SIMPLE ANAL AND RECTAL PROCEDURES
122	S	976	100.00	8.055	0.817	90.53	9.47	MISCELLANEOUS ABDOMINAL PROCEDURES
123	S	1250	99.92	29.031	0.350	91.76	8.24	COMPLEX LAPAROSCOPIC PROCEDURES
124	S	458	100.00	16.180	0.508	88.97	11.03	SIMPLE LAPAROSCOPIC PROCEDURES
131	S	2477	100.00	39.104	0.455	97.29	2.71	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
132	S	2295	100.00	3.287	0.833	96.24	3.76	SIMPLE URINARY STUDIES AND PROCEDURES
133	S	7485	99.49	2.006	1.091	81.12	18.88	URINARY CATHETERIZATION AND DILATATION
134	S	5633	99.98	11.685	0.736	87.67	12.33	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAXY
135	S	8294	99.96	9.093	0.646	86.69	13.31	MODERATE CYSTOURETHROSCOPY
136	S	24603	99.90	4.786	0.770	90.55	9.45	SIMPLE CYSTOURETHROSCOPY
137	S	291	100.00	13.877	0.576	88.26	11.74	COMPLEX URETHRAL PROCEDURES
138	S	172	100.00	8.744	0.616	88.08	11.92	SIMPLE URETHRAL PROCEDURES
139	S	166	100.00	6.821	1.039	88.35	11.65	HEMODIALYSIS
140	S	37	100.00	2.598	0.846	98.42	1.58	PERITONEAL DIALYSIS
151	S	2733	100.00	11.588	0.443	87.23	12.77	TESTICULAR AND EPIDIDYMAL PROCEDURES
152	S	317	100.00	43.883	0.342	96.15	3.85	INSERTION OF PENILE PROSTHESIS
153	S	131	100.00	27.453	0.787	93.70	6.30	COMPLEX PENILE PROCEDURES
154	S	1371	99.85	8.948	0.569	87.94	12.06	SIMPLE PENILE PROCEDURES
155	S	5849	99.97	4.812	0.874	83.51	16.49	PROSTATE NEEDLE AND PUNCH BIOPSY
171	S	8	100.00	2.355	0.829	87.19	12.81	ARTIFICIAL FERTILIZATION
172	S	152	100.00	1.580	0.930	89.86	10.14	PROCEDURES FOR PREGNANCY AND NEONATAL CARE
173	S	42	100.00	10.061	0.426	86.90	13.10	TREATMENT OF SPONTANEOUS ABORTION
174	S	12	100.00	7.868	0.474	86.60	13.40	THERAPEUTIC ABORTION
175	S	1	100.00	1.395	0.000	88.47	11.53	VAGINAL DELIVERY
176	S	142	100.00	13.691	0.658	87.26	12.74	COMPLEX FEMALE REPRODUCTIVE PROCEDURES
177	S	1768	100.00	9.003	0.617	85.18	14.82	SIMPLE FEMALE REPRODUCTIVE PROCEDURES
178	S	4347	99.86	9.589	0.431	82.91	17.09	DILATION AND CURETTAGE
179	S	334	100.00	11.030	0.443	85.88	14.12	HYSTEROSCOPY
180	S	378	100.00	4.111	1.165	85.51	14.49	COLPOSCOPY
191	S	2986	99.97	6.320	0.571	99.13	0.87	EXTENDED EEG STUDIES
192	S	23776	99.12	1.770	0.827	93.30	6.70	ELECTROENCEPHALOGRAM
193	S	1544	99.94	2.688	0.723	90.40	9.60	ELECTROCONVULSIVE THERAPY

Relative Weights Based on Cost with Simple Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
194	S	9264	99.77	1.277	0.991	93.60	6.40	NERVE AND MUSCLE TESTS
195	S	32870	99.73	2.585	0.807	94.00	6.00	NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP
196	S	72	100.00	21.123	1.202	94.29	5.71	REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
197	S	79	100.00	39.410	1.093	96.25	3.75	NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
198	S	11445	99.93	9.352	0.520	89.60	10.40	NERVE REPAIR AND DESTRUCTION
199	S	679	99.85	3.412	0.695	68.66	31.34	SPINAL TAP
211	S	10981	99.93	1.426	0.683	98.15	1.85	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
212	S	9	100.00	1.552	0.621	97.85	2.15	FITTING OF CONTACT LENSES
213	S	76276	99.57	3.115	0.609	99.78	0.22	LASER EYE PROCEDURES
214	S	158641	99.83	16.720	0.403	94.85	5.15	CATARACT PROCEDURES
215	S	1043	100.00	22.863	0.453	93.08	6.92	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES
216	S	4944	100.00	10.786	0.654	92.91	7.09	MODERATE ANTERIOR SEGMENT EYE PROCEDURES
217	S	3357	100.00	6.289	0.905	94.75	5.25	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES
218	S	1242	100.00	17.485	0.763	92.64	7.36	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
219	S	1264	100.00	6.338	1.294	94.08	5.92	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
220	S	469	100.00	11.391	0.484	89.84	10.16	STRABISMUS AND MUSCLE EYE PROCEDURES
221	S	4039	99.98	11.703	0.591	90.40	9.60	COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE
222	S	4762	100.00	6.940	0.848	91.08	8.92	SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
223	S	1423	99.86	19.867	0.487	94.11	5.89	VITRECTOMY
231	S	3	100.00	72.716	0.677	96.33	3.67	COCHLEAR DEVICE IMPLANTATION
232	S	1701	99.71	1.868	0.733	91.44	8.56	OTORHINOLARYNGOLOGIC FUNCTION TESTS
233	S	3491	99.15	1.678	0.823	88.98	11.02	NASAL CAUTERIZATION AND PACKING
234	S	3104	100.00	13.738	0.589	88.50	11.50	COMPLEX FACIAL AND ENT PROCEDURES
235	S	6979	99.99	6.097	0.985	86.01	13.99	SIMPLE FACIAL AND ENT PROCEDURES
236	S	87	98.86	11.439	0.500	85.60	14.40	TONSIL AND ADENOID PROCEDURES
237	S	6809	99.45	1.099	0.739	97.81	2.19	SIMPLE AUDIOMETRY
251	S	2185	100.00	2.930	0.866	95.71	4.29	THERAPEUTIC NUCLEAR MEDICINE
252	S	28509	98.18	1.849	0.982	95.76	4.24	RADIATION THERAPY AND HYPERTHERMIA
253	S	12522	100.00	10.400	0.665	94.04	5.96	VASCULAR RADIOLOGY EXCEPT FOR VENOGRAPHY OF EXTREMITY
254	S	8370	99.84	5.559	0.544	89.70	10.30	MYELOGRAPHY
255	S	93442	99.53	2.124	0.603	89.87	10.13	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
271	S	5838	99.42	1.076	0.965	96.99	3.01	OCCUPATIONAL THERAPY
272	S	40822	99.19	1.296	1.263	91.21	8.79	PHYSICAL THERAPY

Relative Weights Based on Cost with Simple Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
273	S	3773	99.32	1.213	1.014	94.19	5.81	SPEECH THERAPY
281	S	1123	100.00	3.659	1.215	99.28	0.72	NEUROPSYCHOLOGICAL TESTING
282	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
283	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
284	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
285	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
286	S	101120	99.85	1.466	1.040	81.07	18.93	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
287	S	24432	99.81	1.306	0.962	96.54	3.46	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY
288	S	579	100.00	1.048	0.792	99.39	0.61	FAMILY PSYCHOTHERAPY
289	S	4125	99.37	1.075	1.327	99.51	0.49	GROUP PSYCHOTHERAPY
301	A	94567	99.97	4.021	0.497			COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
302	A	142803	99.85	2.510	0.446			INTERMEDIATE DIAGNOSTIC NUCLEAR MEDICINE
303	A	79341	99.90	1.756	0.672			SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
304	A	2637	99.96	1.160	0.555			OBSTETRICAL ULTRASOUND
305	A	379953	99.84	1.322	0.550			DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
306	A	88256	99.88	5.710	0.357			MAGNETIC RESONANCE IMAGING
307	A	535153	99.95	2.947	0.462			COMPUTERIZED AXIAL TOMOGRAPHY
308	A	488216	99.80	0.519	0.516			MAMMOGRAPHY
309	A	294355	99.78	1.171	0.401			DIGESTIVE RADIOLOGY
310	A	2647171	99.48	0.555	0.481			PLAIN FILM
311	A	25541	99.81	1.708	0.980			THERAPEUTIC RADIATION TREATMENT PREPARATION
321	A	325767	99.97	0.870	1.106			ANESTHESIA
331	A	46252	99.79	0.618	1.056			COMPLEX PATHOLOGY
332	A	645170	99.77	0.330	1.007			SIMPLE PATHOLOGY
333	A	130606	99.69	0.084	0.594			PAP SMEARS
341	A	115322	99.84	0.337	1.136			BLOOD AND TISSUE TYPING
342	A	72848	99.32	0.298	0.923			COMPLEX IMMUNOLOGY TESTS
343	A	221774	99.76	0.154	0.826			SIMPLE IMMUNOLOGY TESTS
344	A	147466	99.94	0.284	0.814			COMPLEX MICROBIOLOGY TESTS
345	A	889172	99.81	0.164	0.715			SIMPLE MICROBIOLOGY TESTS
346	A	103913	99.38	0.303	0.802			COMPLEX ENDOCRINOLOGY TESTS
347	A	684027	99.93	0.188	0.690			SIMPLE ENDOCRINOLOGY TESTS
348	A	949642	99.82	0.217	0.612			COMPLEX CHEMISTRY TESTS
349	A	1299622	99.80	0.169	0.913			SIMPLE CHEMISTRY TESTS

Relative Weights Based on Cost with Simple Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
350	A	1493036	99.61	0.095	0.710			BASIC CHEMISTRY TESTS
351	A	2844021	99.96	0.250	0.824			MULTICHANNEL CHEMISTRY TESTS
352	A	530753	99.79	0.279	0.652			ORGAN OR DISEASE ORIENTED PANELS
353	A	39340	99.68	0.254	0.780			TOXICOLOGY TESTS
354	A	344532	99.78	0.236	0.571			THERAPEUTIC DRUG MONITORING
355	A	12236	99.28	0.197	1.042			COMPLEX CLOTTING TESTS
356	A	1324932	99.88	0.096	0.632			SIMPLE CLOTTING TESTS
357	A	1789	99.06	0.129	0.850			COMPLEX HEMATOLOGY TESTS
358	A	3780586	99.92	0.106	0.685			SIMPLE HEMATOLOGY TESTS
359	A	978410	99.92	0.080	0.645			URINALYSIS
360	A	144135	99.83	0.069	0.687			BLOOD AND URINE DIPSTICK TESTS
371	A	147924	99.96	0.492	1.066			SIMPLE PULMONARY FUNCTION TESTS
372	A	146274	99.81	0.221	1.329			INFUSION THERAPY EXCEPT CHEMOTHERAPY
373	A	886603	99.29	0.273	0.657			CARDIOGRAM
374	A	117	100.00	1.598	1.674			COMPLEX IMMUNIZATION
375	A	34	100.00	0.484	0.620			MODERATE IMMUNIZATION
376	A	2583	100.00	0.353	1.831			SIMPLE IMMUNIZATION AND ALLERGY IMMUNOTHERAPY.
377	A	329	99.70	1.335	1.634			MINOR REPRODUCTIVE PROCEDURES
378	A	149560	99.97	1.180	0.743			MINOR CARDIAC AND VASCULAR TESTS
379	A	1453	99.45	1.124	1.082			MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
380	A	54643	99.38	0.282	0.602			PACEMAKER ANALYSIS
381	A	5174	99.98	1.928	1.055			TUBE CHANGE
382	A	522	100.00	2.272	0.763			PROVISION OF VISION AIDS
383	A	2100985	99.19	0.032	0.736			INTRODUCTION OF NEEDLE AND CATHETER
384	A	1602	99.63	0.575	1.007			DRESSINGS AND OTHER MINOR PROCEDURES
385	A	2837	100.00	1.386	1.415			OTHER MISCELANEOUS ANCILLARY PROCEDURES
386	A	130	97.74	0.576	1.105			BIOFEEDBACK AND OTHER TRAINING
391	A	5481	99.95	0.748	2.275			CLASS ONE CHEMOTHERAPY DRUGS
392	A	853	99.30	0.644	1.410			CLASS TWO CHEMOTHERAPY DRUGS
393	A	974	100.00	2.008	1.182			CLASS THREE CHEMOTHERAPY DRUGS
394	A	499	99.60	2.024	0.755			CLASS FOUR CHEMOTHERAPY DRUGS
395	A	312	100.00	4.053	0.606			CLASS FIVE CHEMOTHERAPY DRUGS
411	A	1210	99.34	0.605	0.826			PSYCHOTROPIC MEDICATION MANAGEMENT
412	A	88	98.88	1.138	1.479			ACTIVITY THERAPY

Relative Weights Based on Cost with Simple Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
431	M	15518	99.95	1.780	1.441	80.28	19.72	HEMATOLOGICAL MALIGNANCY
432	M	16111	99.91	0.961	1.324	84.36	15.64	PROSTATIC MALIGNANCY
433	M	9056	99.86	1.610	1.323	71.55	28.45	LUNG MALIGNANCY
434	M	15669	99.76	0.976	1.235	71.13	28.87	BREAST MALIGNANCIES
435	M	12050	99.88	1.320	1.241	74.60	25.40	GI MALIGNANCIES
436	M	6679	99.75	0.862	1.213	79.23	20.77	SKIN MALIGNANCY
437	M	26301	99.87	1.208	1.425	78.89	21.11	OTHER MALIGNANCIES
451	M	8994	99.93	1.888	1.002	73.34	26.66	POISONING
461	M	9130	99.95	2.489	0.869	55.16	44.84	HEAD AND SPINE INJURY
462	M	59447	99.93	1.412	0.736	72.66	27.34	MINOR SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
463	M	81436	99.92	1.979	0.728	57.09	42.91	SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
464	M	124946	99.92	1.949	0.704	57.70	42.30	FRACTURE, DISLOCATION AND SPRAIN
465	M	5069	99.69	1.052	0.840	94.00	6.00	BURNS
466	M	14469	99.77	1.508	0.964	78.25	21.75	OTHER INJURIES
481	M	175	100.00	1.233	0.877	64.42	35.58	NEONATE AND CONGENITAL ANOMALY
491	M	762	99.87	1.185	0.878	87.55	12.45	ROUTINE PRENATAL CARE
492	M	566	99.82	1.688	0.904	85.30	14.70	MATERNAL ANTEPARTUM COMPLICATION
493	M	73	98.65	1.158	0.931	90.04	9.96	ROUTINE POSTPARTUM CARE
494	M	175	100.00	1.628	1.142	79.42	20.58	MATERNAL POSTPARTUM COMPLICATION
501	M	4567	99.89	2.650	0.865	59.15	40.85	COMPLEX INFECTIOUS DISEASE
502	M	13594	99.91	1.655	0.884	64.92	35.08	MISCELLANEOUS INFECTIOUS DISEASES
503	M	4672	99.98	1.141	0.795	78.57	21.43	INFECTIOUS DISEASES OF GENITAL ORGANS
511	M	19203	99.99	2.202	1.103	68.09	31.91	TIA, CVA AND OTHER CEREBROVASCULAR EVENTS
512	M	31945	99.79	1.170	0.908	80.82	19.18	HEADACHE
513	M	4550	99.96	1.470	1.089	78.09	21.91	EPILEPSY
514	M	32661	99.98	2.485	0.904	66.50	33.50	NON TRAUMATIC LOSS OF CONSCIOUSNESS
515	M	34889	99.84	1.187	1.177	77.98	22.02	OTHER DISEASES OF THE NERVOUS SYSTEM
531	M	22535	99.88	0.798	1.272	92.44	7.56	CATARACTS
532	M	2877	99.90	0.698	0.761	98.62	1.38	REFRACTION DISORDER
533	M	10461	99.79	0.793	0.828	93.78	6.22	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION
534	M	83361	99.84	0.788	1.007	95.89	4.11	EYE DISEASES EXCEPT CATARACT,REFRACTION DISORDER & CONJUNCTIVITIS
541	M	2896	99.59	0.842	0.852	87.25	12.75	DENTAL DISEASE

Relative Weights Based on Cost with Simple Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
542	M	57388	99.93	1.026	0.977	71.54	28.46	INFLUENZA, URI AND ENT INFECTIONS.
543	M	4333	99.88	0.818	1.013	94.17	5.83	HEARING LOSS
544	M	26171	99.80	1.532	0.857	77.99	22.01	OTHER COMPLEX EAR, NOSE, THROAT AND MOUTH DISEASES
545	M	30497	99.92	0.911	1.061	82.04	17.96	OTHER SIMPLE EAR, NOSE, THROAT AND MOUTH DISEASES
561	M	81635	99.94	1.485	0.955	63.31	36.69	EMPHYSEMA, CHRONIC BRONCHITIS, AND ASTHMA.
562	M	14691	99.93	2.161	0.790	56.65	43.35	PNEUMONIA
563	M	17734	99.98	2.421	0.857	59.69	40.31	COMPLEX RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
564	M	7477	99.97	1.955	0.869	58.30	41.70	SIMPLE RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
571	M	29495	99.97	2.267	1.251	64.84	35.16	CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
572	M	128040	99.84	0.966	0.992	79.13	20.87	HYPERTENSION
573	M	17097	99.46	3.701	0.593	53.95	46.05	CHEST PAIN W CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
574	M	53657	99.98	2.201	0.855	61.58	38.42	CHEST PAIN WO CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
575	M	69432	99.90	1.288	1.231	72.44	27.56	SIMPLE CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
576	M	24735	99.91	2.235	1.150	70.04	29.96	COMPLEX CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
591	M	23713	99.92	2.252	0.887	60.64	39.36	NONINFECTIOUS GASTROENTERITIS
592	M	31795	99.98	1.891	0.964	63.72	36.28	ULCERS, GASTRITIS AND ESOPHAGITIS
593	M	10227	99.96	2.015	1.108	63.27	36.73	HEPATOBILIARY DISEASE
594	M	8151	99.98	1.368	1.089	67.75	32.25	HERNIA
595	M	9686	99.86	1.364	1.003	75.74	24.26	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
596	M	6929	99.96	2.344	1.084	64.06	35.94	OTHER COMPLEX GASTROINTESTINAL DISEASES
597	M	108094	99.96	2.024	0.909	60.83	39.17	OTHER SIMPLE GASTROINTESTINAL DISEASES
611	M	15605	99.98	4.060	0.936	86.98	13.02	MAJOR SIGNS, SYMPTOMS AND FINDINGS
621	M	44322	99.93	1.490	0.947	63.06	36.94	BACK DISORDERS
622	M	28805	99.82	1.527	0.924	60.84	39.16	COMPLEX MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
623	M	132005	99.95	1.244	0.922	65.14	34.86	SIMPLE MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
631	M	8465	99.86	0.642	0.892	95.83	4.17	DISEASE OF NAILS
632	M	11609	99.59	1.075	1.058	86.40	13.60	CHRONIC SKIN ULCER
633	M	18473	99.82	1.197	0.912	77.35	22.65	CELLULITIS, IMPETIGO AND LYMPHANGITIS

Relative Weights Based on Cost with Simple Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Definition
634	M	6601	99.91	0.833	1.022	82.40	17.60	BREAST DISEASES
635	M	59802	99.86	0.846	0.940	87.17	12.83	SKIN DISEASES
651	M	61700	99.75	0.981	0.997	80.07	19.93	DIABETES
652	M	9920	99.84	2.302	0.888	70.15	29.85	COMPLEX ENDOCRINE,NUTRIT & METABOLIC DIS EXC DIABETES & OBESITY
653	M	21151	99.85	0.842	0.986	77.26	22.74	SIMPLE ENDOCRINE, NUTRITIONAL & METABLIC DISEASE EXC DIABETES
654	M	9322	99.88	3.290	0.892	65.58	34.42	FLUID AND ELECTROLYTE DISORDERS
661	M	42427	99.93	1.823	0.835	58.55	41.45	URINARY TRACT INFECTION
662	M	7743	99.94	1.736	0.982	68.29	31.71	RENAL FAILURE
663	M	31591	99.81	1.562	0.863	72.65	27.35	COMPLEX URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
664	M	19428	99.83	1.143	0.981	78.48	21.52	SIMPLE URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
671	M	9761	99.83	0.684	1.186	77.30	22.70	BENIGN PROSTATIC HYPERTROPHY
672	M	7716	99.88	0.971	0.992	76.44	23.56	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY
681	M	14967	99.88	1.057	0.959	80.84	19.16	GYNECOLOGIC DISEASES
691	M	1967	99.95	1.626	1.041	79.91	20.09	HIV INFECTION
692	M	16128	100.00	2.571	1.051	86.15	13.85	ANEMIA
693	M	5471	99.84	2.773	1.394	88.36	11.64	OTHER COMPLEX IMMUNOLOGIC AND HEMATOLOGIC DISEASE
694	M	11309	99.78	1.460	1.408	80.34	19.66	OTHER SIMPLE IMMUNOLOGIC AND HEMATOLOGIC DISEASE
701	M	4233	99.79	1.034	0.984	78.25	21.75	ADULT MEDICAL EXAMINATION
702	M	3	100.00	1.184	1.141	76.02	23.98	WELL CHILD CARE
703	M	215	99.54	0.681	0.827	92.92	7.08	CONTRACEPTION AND PROCREATIVE MANAGEMENT
704	M	43500	99.74	0.626	1.018	83.36	16.64	AFTERCARE
705	M	102944	99.95	1.653	1.110	67.94	32.06	NONSPECIFIC SIGNS & SYMPTOMS & OTH CONTACTS W HEALTH SVCS
721	M	1357	100.00	2.084	1.209	86.91	13.09	UNKNOWN CAUSE OF MORTALITY

Relative Weights Based on Cost with Limited Packaging

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
001	S	1120	98.68	0.318	1.088	99.95	0.05	PHOTOCHEMOTHERAPY
002	S	7518	99.99	2.172	1.152	98.53	1.47	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
003	S	597	100.00	3.495	1.102	96.08	3.92	COMPLEX INCISION AND DRAINAGE
004	S	3091	100.00	1.841	1.383	97.04	2.96	SIMPLE INCISION AND DRAINAGE
005	S	1612	99.44	0.489	1.269	99.95	0.05	NAIL PROCEDURES
006	S	11392	100.00	2.146	1.504	97.02	2.98	SIMPLE DEBRIDEMENT AND DESTRUCTION
007	S	12944	100.00	4.423	0.893	95.66	4.34	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
008	S	29900	100.00	3.382	0.988	96.36	3.64	SIMPLE EXCISION AND BIOPSY
009	S	3915	100.00	6.652	0.711	94.97	5.03	COMPLEX SKIN REPAIRS INCL INTEGUMENT GRAFTS, TRANSFER & REARRANGE
010	S	22956	98.96	1.148	0.626	99.54	0.46	SIMPLE SKIN REPAIR
011	S	12620	100.00	5.611	0.714	94.28	5.72	SIMPLE INCISION AND EXCISION OF BREAST
012	S	1154	100.00	8.516	0.600	94.15	5.85	BREAST RECONSTRUCTION AND MASTECTOMY
021	S	1294	100.00	10.750	0.606	94.53	5.47	COMPLEX MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT.
022	S	1685	100.00	6.789	0.661	94.41	5.59	SIMPLE MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
023	S	2261	100.00	9.207	0.569	94.01	5.99	COMPLEX HAND AND FOOT MUSCULOSKELETAL PROCEDURES
024	S	11802	99.98	6.680	0.624	94.83	5.17	SIMPLE HAND AND FOOT MUSCULOSKELETAL PROCEDURES
025	S	6170	99.85	11.652	0.428	94.95	5.05	ARTHROSCOPY
026	S	1498	99.53	1.272	0.728	99.67	0.33	REPLACEMENT OF CAST
027	S	4259	99.60	0.849	0.737	99.83	0.17	SPLINT, STRAPPING AND CAST REMOVAL
028	S	1383	99.00	1.106	0.804	99.26	0.74	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK
029	S	6089	99.27	1.920	1.303	96.80	3.20	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK
030	S	983	100.00	9.551	0.753	95.26	4.74	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES
031	S	606	100.00	5.111	0.765	92.92	7.08	BONE OR JOINT MANIPULATION UNDER ANESTHESIA
032	S	2172	99.86	10.636	0.506	94.34	5.66	BUNION PROCEDURES
033	S	522	99.81	11.951	0.570	95.77	4.23	ARTHROPLASTY
034	S	250	100.00	5.817	0.646	95.18	4.82	HAND AND FOOT TENOTOMY
035	S	4564	99.74	1.134	1.105	98.09	1.91	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION
051	S	88896	99.97	1.451	1.288	99.17	0.83	PULMONARY TESTS

Relative Weights Based on Cost with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
052	S	4718	99.43	1.756	0.863	99.43	0.57	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION
053	S	2705	100.00	8.370	0.517	93.03	6.97	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY
054	S	1751	100.00	3.173	1.176	94.92	5.08	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
055	S	8763	99.87	4.238	0.660	97.73	2.27	ENDOSCOPY OF THE LOWER AIRWAY
057	S	44606	99.97	1.489	1.261	99.09	0.91	RESPIRATORY THERAPY
071	S	106046	99.87	1.215	0.746	99.91	0.09	EXERCISE TOLERANCE TESTS
072	S	48005	99.72	1.487	0.927	99.86	0.14	ECHOCARDIOGRAPHY
073	S	1185	99.83	0.980	0.981	99.27	0.73	PHONOCARDIOGRAM
074	S	376	100.00	11.188	0.769	99.22	0.78	CARDIAC ELECTROPHYSIOLOGIC TESTS
075	S	3156	99.97	6.678	0.862	97.31	2.69	PLACEMENT OF TRANSVENOUS CATHETERS.
076	S	17133	99.99	15.140	0.468	99.92	0.08	DIAGNOSTIC CARDIAC CATHETERIZATION
077	S	552	100.00	9.645	0.827	99.62	0.38	ANGIOPLASTY AND TRANSCATHETER PROCEDURES
078	S	1095	100.00	37.766	0.568	99.15	0.85	PACEMAKER INSERTION AND REPLACEMENT
079	S	1132	99.91	6.092	1.320	96.25	3.75	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
080	S	7075	100.00	11.025	0.588	96.09	3.91	MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
081	S	385	100.00	5.045	0.972	97.35	2.65	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
082	S	362	100.00	9.678	0.642	94.32	5.68	VASCULAR LIGATION
083	S	3736	99.95	3.554	0.997	99.25	0.75	RESUSCITATION AND CARDIOVERSION
084	S	6778	99.54	0.836	1.479	99.95	0.05	CARDIAC REHABILITATION
091	S	2426	100.00	1.385	1.481	99.42	0.58	CHEMOTHERAPY BY EXTENDED INFUSION
092	S	2571	100.00	2.027	1.180	99.64	0.36	CHEMOTHERAPY EXCEPT BY EXTENDED INFUSION
093	S	3953	99.77	0.472	1.966	98.50	1.50	PHLEBOTOMY
094	S	557	100.00	6.656	0.743	99.81	0.19	BLOOD AND BLOOD PRODUCT EXCHANGE
095	S	2676	100.00	6.637	0.688	94.40	5.60	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
096	S	1428	100.00	1.150	1.035	99.64	0.36	ALLERGY TESTS
097	S	13827	99.91	3.405	0.721	99.74	0.26	TRANSFUSION
111	S	4086	100.00	1.838	0.828	99.85	0.15	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
112	S	4903	99.98	2.182	0.800	99.36	0.64	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
113	S	29638	99.53	1.470	0.829	99.39	0.61	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
114	S	5850	99.83	2.577	0.882	98.70	1.30	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
115	S	67204	99.74	3.053	0.609	99.10	0.90	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION
116	S	11160	99.95	3.684	0.730	98.96	1.04	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION

Relative Weights Based on Cost with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
117	S	118355	99.73	3.605	0.560	99.10	0.90	LOWER GASTROINTESTINAL ENDOSCOPY
118	S	1397	100.00	4.756	0.845	99.48	0.52	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES
119	S	15440	99.85	10.493	0.469	94.27	5.73	HERNIA AND HYDROCELE PROCEDURES
120	S	1597	100.00	7.963	0.574	94.23	5.77	COMPLEX ANAL AND RECTAL PROCEDURES
121	S	1325	100.00	3.875	1.153	95.30	4.70	SIMPLE ANAL AND RECTAL PROCEDURES
122	S	976	100.00	5.764	0.828	95.97	4.03	MISCELLANEOUS ABDOMINAL PROCEDURES
123	S	1250	99.92	21.063	0.356	95.94	4.06	COMPLEX LAPAROSCOPIC PROCEDURES
124	S	458	100.00	11.589	0.522	94.23	5.77	SIMPLE LAPAROSCOPIC PROCEDURES
131	S	2477	100.00	29.126	0.460	99.10	0.90	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
132	S	2295	100.00	2.416	0.830	99.33	0.67	SIMPLE URINARY STUDIES AND PROCEDURES
133	S	7461	99.18	1.220	1.121	98.61	1.39	URINARY CATHETERIZATION AND DILATATION
134	S	5633	99.98	8.201	0.764	94.76	5.24	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAXY
135	S	8294	99.96	6.337	0.661	94.37	5.63	MODERATE CYSTOURETHROSCOPY
136	S	24603	99.90	3.417	0.771	96.21	3.79	SIMPLE CYSTOURETHROSCOPY
137	S	291	100.00	9.837	0.595	94.46	5.54	COMPLEX URETHRAL PROCEDURES
138	S	172	100.00	6.150	0.632	95.02	4.98	SIMPLE URETHRAL PROCEDURES
139	S	166	100.00	4.577	1.063	99.90	0.10	HEMODIALYSIS
140	S	37	100.00	1.940	0.832	100.00	0.00	PERITONEAL DIALYSIS
151	S	2733	100.00	8.152	0.457	94.07	5.93	TESTICULAR AND EPIDIDYMAL PROCEDURES
152	S	317	100.00	32.510	0.349	98.46	1.54	INSERTION OF PENILE PROSTHESIS
153	S	131	100.00	20.088	0.810	97.16	2.84	COMPLEX PENILE PROCEDURES
154	S	1371	99.85	6.307	0.580	94.65	5.35	SIMPLE PENILE PROCEDURES
155	S	5850	99.98	3.192	0.950	95.67	4.33	PROSTATE NEEDLE AND PUNCH BIOPSY
171	S	8	100.00	1.559	0.767	99.90	0.10	ARTIFICIAL FERTILIZATION
172	S	152	100.00	1.079	0.939	99.83	0.17	PROCEDURES FOR PREGNANCY AND NEONATAL CARE
173	S	42	100.00	7.046	0.447	94.13	5.87	TREATMENT OF SPONTANEOUS ABORTION
174	S	12	100.00	5.484	0.476	94.25	5.75	THERAPEUTIC ABORTION
175	S	1	100.00	0.945	0.000	99.04	0.96	VAGINAL DELIVERY
176	S	142	100.00	9.628	0.691	94.13	5.87	COMPLEX FEMALE REPRODUCTIVE PROCEDURES
177	S	1768	100.00	6.244	0.645	93.18	6.82	SIMPLE FEMALE REPRODUCTIVE PROCEDURES
178	S	4349	99.91	6.534	0.458	92.43	7.57	DILATION AND CURETTAGE
179	S	334	100.00	7.731	0.469	92.95	7.05	HYSTEROSCOPY
180	S	378	100.00	2.761	1.243	96.59	3.41	COLPOSCOPY

Relative Weights Based on Cost with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
191	S	2986	99.97	4.754	0.577	99.99	0.01	EXTENDED EEG STUDIES
192	S	23782	99.14	1.255	0.799	99.83	0.17	ELECTROENCEPHALOGRAM
193	S	1544	99.94	2.008	0.718	91.79	8.21	ELECTROCONVULSIVE THERAPY
194	S	9261	99.74	0.905	0.997	99.93	0.07	NERVE AND MUSCLE TESTS
195	S	32874	99.75	1.904	0.797	96.89	3.11	NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP
196	S	72	100.00	15.634	1.228	96.65	3.35	REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
197	S	79	100.00	29.140	1.127	98.75	1.25	NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
198	S	11445	99.93	6.742	0.522	94.29	5.71	NERVE REPAIR AND DESTRUCTION
199	S	679	99.85	1.794	0.860	99.06	0.94	SPINAL TAP
211	S	10973	99.85	1.058	0.664	99.95	0.05	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
212	S	9	100.00	1.152	0.665	100.00	0.00	FITTING OF CONTACT LENSES
213	S	76287	99.58	2.362	0.610	99.88	0.12	LASER EYE PROCEDURES
214	S	158645	99.84	12.417	0.405	96.91	3.09	CATARACT PROCEDURES
215	S	1043	100.00	16.684	0.462	96.77	3.23	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES
216	S	4944	100.00	7.935	0.655	95.81	4.19	MODERATE ANTERIOR SEGMENT EYE PROCEDURES
217	S	3357	100.00	4.656	0.895	97.11	2.89	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES
218	S	1242	100.00	12.850	0.773	95.63	4.37	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
219	S	1264	100.00	4.666	1.289	96.95	3.05	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
220	S	469	100.00	8.304	0.484	93.49	6.51	STRABISMUS AND MUSCLE EYE PROCEDURES
221	S	4039	99.98	8.475	0.598	94.69	5.31	COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE
222	S	4762	100.00	5.016	0.856	95.59	4.41	SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
223	S	1423	99.86	14.658	0.490	96.77	3.23	VITRECTOMY
231	S	3	100.00	55.067	0.677	96.50	3.50	COCHLEAR DEVICE IMPLANTATION
232	S	1702	99.77	1.298	0.722	99.91	0.09	OTORHINOLARYNGOLOGIC FUNCTION TESTS
233	S	3487	99.03	1.133	0.816	99.30	0.70	NASAL CAUTERIZATION AND PACKING
234	S	3104	100.00	9.813	0.611	93.99	6.01	COMPLEX FACIAL AND ENT PROCEDURES
235	S	6979	99.99	4.214	1.026	94.40	5.60	SIMPLE FACIAL AND ENT PROCEDURES
236	S	88	100.00	8.299	0.632	93.85	6.15	TONSIL AND ADENOID PROCEDURES
237	S	6802	99.34	0.811	0.719	99.95	0.05	SIMPLE AUDIOMETRY
251	S	2185	100.00	2.128	0.881	99.97	0.03	THERAPEUTIC NUCLEAR MEDICINE
252	S	28526	98.24	1.350	0.978	99.91	0.09	RADIATION THERAPY AND HYPERTHERMIA
253	S	12522	100.00	7.442	0.677	99.70	0.30	VASCULAR RADIOLOGY EXCEPT FOR VENOGRAPHY OF EXTREMITY
254	S	8372	99.87	3.790	0.559	99.87	0.13	MYELOGRAPHY

Relative Weights Based on Cost with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
255	S	93451	99.54	1.451	0.558	99.77	0.23	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
271	S	5839	99.44	0.793	0.966	99.93	0.07	OCCUPATIONAL THERAPY
272	S	40762	99.04	0.885	1.228	99.84	0.16	PHYSICAL THERAPY
273	S	3765	99.11	0.854	0.990	99.99	0.01	SPEECH THERAPY
281	S	1123	100.00	2.756	1.215	99.99	0.01	NEUROPSYCHOLOGICAL TESTING
282	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
283	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
284	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
285	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
286	S	100983	99.72	0.892	1.008	99.59	0.41	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
287	S	24429	99.80	0.956	0.931	99.89	0.11	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY
288	S	579	100.00	0.790	0.781	99.99	0.01	FAMILY PSYCHOTHERAPY
289	S	4125	99.37	0.812	1.331	99.89	0.11	GROUP PSYCHOTHERAPY
301	A	94567	99.97	3.050	0.497			COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
302	A	142803	99.85	1.904	0.446			INTERMEDIATE DIAGNOSTIC NUCLEAR MEDICINE
303	A	79341	99.90	1.332	0.672			SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
304	A	2637	99.96	0.880	0.555			OBSTETRICAL ULTRASOUND
305	A	379953	99.84	1.003	0.550			DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
306	A	88256	99.88	4.332	0.357			MAGNETIC RESONANCE IMAGING
307	A	535153	99.95	2.236	0.462			COMPUTERIZED AXIAL TOMOGRAPHY
308	A	488216	99.80	0.394	0.516			MAMMOGRAPHY
309	A	294355	99.78	0.888	0.401			DIGESTIVE RADIOLOGY
310	A	2647171	99.48	0.421	0.481			PLAIN FILM
311	A	25541	99.81	1.295	0.980			THERAPEUTIC RADIATION TREATMENT PREPARATION
321	A	325767	99.97	0.660	1.106			ANESTHESIA
331	A	46252	99.79	0.469	1.056			COMPLEX PATHOLOGY
332	A	645170	99.77	0.250	1.007			SIMPLE PATHOLOGY
333	A	130606	99.69	0.064	0.594			PAP SMEARS
341	A	115322	99.84	0.256	1.136			BLOOD AND TISSUE TYPING
342	A	72848	99.32	0.226	0.923			COMPLEX IMMUNOLOGY TESTS
343	A	221774	99.76	0.117	0.826			SIMPLE IMMUNOLOGY TESTS
344	A	147466	99.94	0.216	0.814			COMPLEX MICROBIOLOGY TESTS
345	A	889172	99.81	0.125	0.715			SIMPLE MICROBIOLOGY TESTS

Relative Weights Based on Cost with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
346	A	103913	99.38	0.230	0.802			COMPLEX ENDOCRINOLOGY TESTS
347	A	684027	99.93	0.142	0.690			SIMPLE ENDOCRINOLOGY TESTS
348	A	949642	99.82	0.165	0.612			COMPLEX CHEMISTRY TESTS
349	A	1299622	99.80	0.128	0.913			SIMPLE CHEMISTRY TESTS
350	A	1493036	99.61	0.072	0.710			BASIC CHEMISTRY TESTS
351	A	2844021	99.96	0.190	0.824			MULTICHANNEL CHEMISTRY TESTS
352	A	530753	99.79	0.212	0.652			ORGAN OR DISEASE ORIENTED PANELS
353	A	39340	99.68	0.193	0.780			TOXICOLOGY TESTS
354	A	344532	99.78	0.179	0.571			THERAPEUTIC DRUG MONITORING
355	A	12236	99.28	0.149	1.042			COMPLEX CLOTTING TESTS
356	A	1324932	99.88	0.073	0.632			SIMPLE CLOTTING TESTS
357	A	1789	99.06	0.098	0.850			COMPLEX HEMATOLOGY TESTS
358	A	3780586	99.92	0.080	0.685			SIMPLE HEMATOLOGY TESTS
359	A	978410	99.92	0.061	0.645			URINALYSIS
360	A	144135	99.83	0.052	0.687			BLOOD AND URINE DIPSTICK TESTS
371	A	147924	99.96	0.373	1.066			SIMPLE PULMONARY FUNCTION TESTS
372	A	146274	99.81	0.168	1.329			INFUSION THERAPY EXCEPT CHEMOTHERAPY
373	A	886603	99.29	0.207	0.657			CARDIOGRAM
374	A	117	100.00	1.212	1.674			COMPLEX IMMUNIZATION
375	A	34	100.00	0.367	0.620			MODERATE IMMUNIZATION
376	A	2583	100.00	0.268	1.831			SIMPLE IMMUNIZATION AND ALLERGY IMMUNOTHERAPY.
377	A	329	99.70	1.013	1.634			MINOR REPRODUCTIVE PROCEDURES
378	A	149560	99.97	0.896	0.743			MINOR CARDIAC AND VASCULAR TESTS
379	A	1453	99.45	0.853	1.082			MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
380	A	54643	99.38	0.214	0.602			PACEMAKER ANALYSIS
381	A	5174	99.98	1.462	1.055			TUBE CHANGE
382	A	522	100.00	1.724	0.763			PROVISION OF VISION AIDS
383	A	2100985	99.19	0.024	0.736			INTRODUCTION OF NEEDLE AND CATHETER
384	A	1602	99.63	0.436	1.007			DRESSINGS AND OTHER MINOR PROCEDURES
385	A	2837	100.00	1.051	1.415			OTHER MISCELANEOUS ANCILLARY PROCEDURES
386	A	130	97.74	0.437	1.105			BIOFEEDBACK AND OTHER TRAINING
391	A	5481	99.95	0.567	2.275			CLASS ONE CHEMOTHERAPY DRUGS
392	A	853	99.30	0.488	1.410			CLASS TWO CHEMOTHERAPY DRUGS

Relative Weights Based on Cost with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
393	A	974	100.00	1.523	1.182			CLASS THREE CHEMOTHERAPY DRUGS
394	A	499	99.60	1.536	0.755			CLASS FOUR CHEMOTHERAPY DRUGS
395	A	312	100.00	3.075	0.606			CLASS FIVE CHEMOTHERAPY DRUGS
411	A	1210	99.34	0.459	0.826			PSYCHOTROPIC MEDICATION MANAGEMENT
412	A	88	98.88	0.863	1.479			ACTIVITY THERAPY
431	M	15517	99.95	1.090	1.709	99.31	0.69	HEMATOLOGICAL MALIGNANCY
432	M	16104	99.87	0.616	1.414	99.24	0.76	PROSTATIC MALIGNANCY
433	M	9044	99.72	0.858	1.552	99.49	0.51	LUNG MALIGNANCY
434	M	15615	99.42	0.506	1.305	99.20	0.80	BREAST MALIGNANCIES
435	M	12041	99.81	0.744	1.399	99.34	0.66	GI MALIGNANCIES
436	M	6668	99.58	0.509	1.181	99.69	0.31	SKIN MALIGNANCY
437	M	26240	99.64	0.700	1.471	99.55	0.45	OTHER MALIGNANCIES
451	M	8978	99.76	1.039	1.015	99.36	0.64	POISONING
461	M	9080	99.40	0.991	0.955	99.71	0.29	HEAD AND SPINE INJURY
462	M	59342	99.75	0.770	0.692	99.90	0.10	MINOR SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
463	M	81153	99.58	0.840	0.708	99.81	0.19	SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
464	M	124742	99.76	0.844	0.768	99.86	0.14	FRACTURE, DISLOCATION AND SPRAIN
465	M	5066	99.63	0.747	0.774	99.92	0.08	BURNS
466	M	14434	99.52	0.880	0.929	99.75	0.25	OTHER INJURIES
481	M	175	100.00	0.605	0.894	99.64	0.36	NEONATE AND CONGENITAL ANOMALY
491	M	762	99.87	0.790	0.900	99.64	0.36	ROUTINE PRENATAL CARE
492	M	565	99.65	1.077	0.921	99.73	0.27	MATERNAL ANTEPARTUM COMPLICATION
493	M	73	98.65	0.793	1.018	99.80	0.20	ROUTINE POSTPARTUM CARE
494	M	173	98.86	0.885	0.883	99.03	0.97	MATERNAL POSTPARTUM COMPLICATION
501	M	4554	99.61	1.168	1.029	98.89	1.11	COMPLEX INFECTIOUS DISEASE
502	M	13552	99.60	0.797	0.866	99.22	0.78	MISCELLANEOUS INFECTIOUS DISEASES
503	M	4673	100.00	0.684	0.781	99.62	0.38	INFECTIOUS DISEASES OF GENITAL ORGANS
511	M	19189	99.92	1.131	1.227	99.37	0.63	TIA, CVA AND OTHER CEREBROVASCULAR EVENTS
512	M	31893	99.63	0.712	0.791	99.62	0.38	HEADACHE
513	M	4546	99.87	0.871	1.056	99.07	0.93	EPILEPSY
514	M	32617	99.84	1.243	0.992	99.25	0.75	NON TRAUMATIC LOSS OF CONSCIOUSNESS
515	M	34824	99.66	0.689	1.121	99.55	0.45	OTHER DISEASES OF THE NERVOUS SYSTEM
531	M	22527	99.85	0.558	1.288	99.81	0.19	CATARACTS

Relative Weights Based on Cost with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
532	M	2877	99.90	0.522	0.755	99.95	0.05	REFRACTION DISORDER
533	M	10462	99.80	0.564	0.783	99.90	0.10	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION
534	M	83364	99.84	0.574	0.996	99.89	0.11	EYE DISEASES EXCEPT CATARACT,REFRACTION DISORDER & CONJUNCTIVITIS
541	M	2895	99.55	0.555	0.749	99.77	0.23	DENTAL DISEASE
542	M	57285	99.75	0.551	0.841	99.49	0.51	INFLUENZA, URI AND ENT INFECTIONS.
543	M	4334	99.91	0.586	0.993	99.87	0.13	HEARING LOSS
544	M	26115	99.59	0.897	0.820	99.40	0.60	OTHER COMPLEX EAR, NOSE, THROAT AND MOUTH DISEASES
545	M	30453	99.78	0.559	0.942	99.66	0.34	OTHER SIMPLE EAR, NOSE, THROAT AND MOUTH DISEASES
561	M	81525	99.81	0.707	0.950	99.26	0.74	EMPHYSEMA, CHRONIC BRONCHITIS, AND ASTHMA.
562	M	14668	99.77	0.922	0.922	99.02	0.98	PNEUMONIA
563	M	17717	99.88	1.091	1.000	99.26	0.74	COMPLEX RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
564	M	7466	99.83	0.856	0.969	99.18	0.82	SIMPLE RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
571	M	29402	99.65	1.063	1.316	99.19	0.81	CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
572	M	127956	99.77	0.579	0.921	99.43	0.57	HYPERTENSION
573	M	17113	99.55	1.537	0.888	99.08	0.92	CHEST PAIN W CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
574	M	53582	99.84	1.017	0.959	99.42	0.58	CHEST PAIN WO CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
575	M	69326	99.75	0.696	1.192	99.36	0.64	SIMPLE CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
576	M	24715	99.83	1.176	1.243	99.37	0.63	COMPLEX CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
591	M	23621	99.53	1.007	0.983	99.10	0.90	NONINFECTIOUS GASTROENTERITIS
592	M	31726	99.76	0.898	1.009	99.26	0.74	ULCERS, GASTRITIS AND ESOPHAGITIS
593	M	10200	99.70	0.937	1.167	99.23	0.77	HEPATOBILIARY DISEASE
594	M	8130	99.72	0.685	1.032	99.42	0.58	HERNIA
595	M	9665	99.64	0.772	0.974	99.37	0.63	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
596	M	6925	99.90	1.137	1.300	99.37	0.63	OTHER COMPLEX GASTROINTESTINAL DISEASES
597	M	107781	99.67	0.913	0.961	99.26	0.74	OTHER SIMPLE GASTROINTESTINAL DISEASES
611	M	15605	99.98	2.685	1.005	99.79	0.21	MAJOR SIGNS, SYMPTOMS AND FINDINGS
621	M	44197	99.65	0.695	0.892	99.65	0.35	BACK DISORDERS

Relative Weights Based on Cost with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
622	M	28725	99.55	0.685	0.933	99.63	0.37	COMPLEX MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
623	M	131859	99.83	0.610	0.882	99.54	0.46	SIMPLE MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
631	M	8466	99.87	0.467	0.868	99.95	0.05	DISEASE OF NAILS
632	M	11591	99.43	0.694	0.985	99.80	0.20	CHRONIC SKIN ULCER
633	M	18450	99.70	0.697	0.844	99.55	0.45	CELLULITIS, IMPETIGO AND LYMPHANGITIS
634	M	6597	99.85	0.519	0.981	99.65	0.35	BREAST DISEASES
635	M	59773	99.81	0.558	0.870	99.74	0.26	SKIN DISEASES
651	M	61656	99.68	0.596	0.960	99.18	0.82	DIABETES
652	M	9909	99.73	1.220	1.004	99.27	0.73	COMPLEX ENDOCRINE,NUTRIT & METABOLIC DIS EXC DIABETES & OBESITY
653	M	21130	99.75	0.492	0.944	99.19	0.81	SIMPLE ENDOCRINE, NUTRITIONAL & METABLIC DISEASE EXC DIABETES
654	M	9314	99.80	1.635	1.104	99.21	0.79	FLUID AND ELECTROLYTE DISORDERS
661	M	42350	99.75	0.801	0.868	99.16	0.84	URINARY TRACT INFECTION
662	M	7725	99.70	0.882	1.039	99.31	0.69	RENAL FAILURE
663	M	31570	99.74	0.860	0.909	99.45	0.55	COMPLEX URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
664	M	19401	99.69	0.674	0.958	99.61	0.39	SIMPLE URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
671	M	9753	99.74	0.400	1.134	99.09	0.91	BENIGN PROSTATIC HYPERTROPHY
672	M	7708	99.78	0.560	0.953	99.36	0.64	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY
681	M	14956	99.81	0.646	0.919	99.53	0.47	GYNECOLOGIC DISEASES
691	M	1964	99.80	0.974	1.060	99.53	0.47	HIV INFECTION
692	M	16127	99.99	1.686	1.147	99.54	0.46	ANEMIA
693	M	5471	99.84	1.865	1.549	99.64	0.36	OTHER COMPLEX IMMUNOLOGIC AND HEMATOLOGIC DISEASE
694	M	11289	99.60	0.872	1.517	99.34	0.66	OTHER SIMPLE IMMUNOLOGIC AND HEMATOLOGIC DISEASE
701	M	4231	99.74	0.614	1.008	99.37	0.63	ADULT MEDICAL EXAMINATION
702	M	3	100.00	0.683	1.077	100.00	0.00	WELL CHILD CARE
703	M	215	99.54	0.481	0.856	99.79	0.21	CONTRACEPTION AND PROCREATIVE MANAGEMENT
704	M	43493	99.72	0.395	0.969	99.79	0.21	AFTERCARE
705	M	102703	99.72	0.829	1.187	99.38	0.62	NONSPECIFIC SIGNS & SYMPTOMS & OTH CONTACTS W HEALTH SVCS
721	M	1356	99.93	1.364	1.274	99.80	0.20	UNKNOWN CAUSE OF MORTALITY.

Relative Weights Based on Charges with Full Packaging

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
001	S	1118	98.50	0.237	0.866	97.22	2.78	PHOTOCHEMOTHERAPY
002	S	7515	99.95	3.532	0.939	68.72	31.28	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
003	S	597	100.00	4.881	1.191	82.69	17.31	COMPLEX INCISION AND DRAINAGE
004	S	3089	99.94	2.510	1.488	80.66	19.34	SIMPLE INCISION AND DRAINAGE
005	S	1612	99.44	0.383	0.999	92.17	7.83	NAIL PROCEDURES
006	S	11392	100.00	2.717	1.696	86.41	13.59	SIMPLE DEBRIDEMENT AND DESTRUCTION
007	S	12944	100.00	6.113	0.930	82.51	17.49	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
008	S	29900	100.00	4.636	1.014	81.49	18.51	SIMPLE EXCISION AND BIOPSY
009	S	3915	100.00	9.168	0.752	84.92	15.08	COMPLEX SKIN REPAIRS INCL INTEGUMENT GRAFTS, TRANSFER & REARRANGE
010	S	23046	99.35	1.612	0.809	70.58	29.42	SIMPLE SKIN REPAIR
011	S	12620	100.00	8.099	0.707	79.62	20.38	SIMPLE INCISION AND EXCISION OF BREAST
012	S	1154	100.00	12.429	0.643	81.62	18.38	BREAST RECONSTRUCTION AND MASTECTOMY
021	S	1294	100.00	15.297	0.623	85.55	14.45	COMPLEX MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT.
022	S	1684	99.94	9.578	0.706	83.01	16.99	SIMPLE MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
023	S	2261	100.00	12.703	0.589	84.69	15.31	COMPLEX HAND AND FOOT MUSCULOSKELETAL PROCEDURES
024	S	11801	99.97	9.149	0.652	84.93	15.07	SIMPLE HAND AND FOOT MUSCULOSKELETAL PROCEDURES
025	S	6174	99.92	16.208	0.458	87.55	12.45	ARTHROSCOPY
026	S	1495	99.34	1.561	0.722	70.73	29.27	REPLACEMENT OF CAST
027	S	4265	99.74	1.264	0.789	62.78	37.22	SPLINT, STRAPPING AND CAST REMOVAL
028	S	1386	99.21	2.080	0.738	49.31	50.69	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK
029	S	6091	99.30	3.070	1.219	63.74	36.26	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK
030	S	983	100.00	14.141	0.770	81.90	18.10	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES
031	S	606	100.00	7.380	0.724	77.75	22.25	BONE OR JOINT MANIPULATION UNDER ANESTHESIA
032	S	2174	99.95	14.910	0.543	85.15	14.85	BUNION PROCEDURES
033	S	523	100.00	16.674	0.602	88.22	11.78	ARTHROPLASTY
034	S	250	100.00	7.754	0.701	85.52	14.48	HAND AND FOOT TENOTOMY
035	S	4554	99.52	1.451	1.161	79.29	20.71	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION
051	S	88896	99.97	2.895	0.946	54.77	45.23	PULMONARY TESTS
052	S	4736	99.81	3.086	0.737	66.56	33.44	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION
053	S	2704	99.96	12.069	0.531	80.31	19.69	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY

Relative Weights Based on Charges with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
054	S	1751	100.00	4.257	1.332	80.13	19.87	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
055	S	8766	99.91	7.151	0.575	70.30	29.70	ENDOSCOPY OF THE LOWER AIRWAY
057	S	44607	99.97	2.919	0.944	55.99	44.01	RESPIRATORY THERAPY
071	S	106022	99.84	2.255	0.654	95.12	4.88	EXERCISE TOLERANCE TESTS
072	S	47983	99.68	2.579	0.609	90.16	9.84	ECHOCARDIOGRAPHY
073	S	1187	100.00	2.039	0.961	63.89	36.11	PHONOCARDIOGRAM
074	S	376	100.00	14.903	0.693	94.10	5.90	CARDIAC ELECTROPHYSIOLOGIC TESTS
075	S	3157	100.00	10.082	0.870	85.66	14.34	PLACEMENT OF TRANSVENOUS CATHETERS.
076	S	17131	99.98	19.834	0.452	94.88	5.12	DIAGNOSTIC CARDIAC CATHETERIZATION
077	S	552	100.00	13.800	0.858	92.87	7.13	ANGIOPLASTY AND TRANSCATHETER PROCEDURES
078	S	1095	100.00	55.766	0.471	96.33	3.67	PACEMAKER INSERTION AND REPLACEMENT
079	S	1133	100.00	8.718	1.359	87.63	12.37	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
080	S	7075	100.00	15.959	0.602	88.13	11.87	MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
081	S	385	100.00	6.522	1.041	89.74	10.26	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
082	S	362	100.00	13.437	0.721	86.15	13.85	VASCULAR LIGATION
083	S	3737	99.97	4.811	0.934	86.70	13.30	RESUSCITATION AND CARDIOVERSION
084	S	6758	99.25	0.755	1.413	95.50	4.50	CARDIAC REHABILITATION
091	S	2422	99.84	1.971	1.279	86.02	13.98	CHEMOTHERAPY BY EXTENDED INFUSION
092	S	2571	100.00	2.979	1.307	94.87	5.13	CHEMOTHERAPY EXCEPT BY EXTENDED INFUSION
093	S	3937	99.37	0.778	1.442	61.36	38.64	PHLEBOTOMY
094	S	557	100.00	8.258	0.915	94.99	5.01	BLOOD AND BLOOD PRODUCT EXCHANGE
095	S	2676	100.00	9.695	0.699	79.50	20.50	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
096	S	1428	100.00	1.636	1.073	58.77	41.23	ALLERGY TESTS
097	S	13802	99.73	3.861	0.687	91.71	8.29	TRANSFUSION
111	S	4086	100.00	2.902	0.819	85.67	14.33	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
112	S	4904	100.00	2.889	0.808	93.34	6.66	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
113	S	29640	99.54	1.794	0.827	92.53	7.47	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
114	S	5851	99.85	3.563	0.818	85.59	14.41	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
115	S	67270	99.84	4.199	0.564	89.52	10.48	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION
116	S	11165	99.99	4.984	0.725	90.99	9.01	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION
117	S	118465	99.82	4.847	0.514	90.42	9.58	LOWER GASTROINTESTINAL ENDOSCOPY
118	S	1397	100.00	6.792	0.798	87.43	12.57	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES
119	S	15450	99.92	14.251	0.498	85.94	14.06	HERNIA AND HYDROCELE PROCEDURES
120	S	1597	100.00	11.093	0.584	83.98	16.02	COMPLEX ANAL AND RECTAL PROCEDURES
121	S	1325	100.00	5.008	1.147	83.26	16.74	SIMPLE ANAL AND RECTAL PROCEDURES

Relative Weights Based on Charges with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
122	S	976	100.00	8.064	0.882	87.37	12.63	MISCELLANEOUS ABDOMINAL PROCEDURES
123	S	1251	100.00	30.788	0.380	88.67	11.33	COMPLEX LAPAROSCOPIC PROCEDURES
124	S	458	100.00	16.540	0.545	85.61	14.39	SIMPLE LAPAROSCOPIC PROCEDURES
131	S	2477	100.00	34.734	0.372	96.19	3.81	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
132	S	2293	99.91	2.890	0.794	94.09	5.91	SIMPLE URINARY STUDIES AND PROCEDURES
133	S	7481	99.44	1.691	1.218	72.88	27.12	URINARY CATHETERIZATION AND DILATATION
134	S	5634	100.00	11.794	0.787	84.09	15.91	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAXY
135	S	8295	99.98	8.925	0.689	82.38	17.62	MODERATE CYSTOURETHROSCOPY
136	S	24601	99.89	4.328	0.828	86.80	13.20	SIMPLE CYSTOURETHROSCOPY
137	S	291	100.00	14.493	0.603	84.21	15.79	COMPLEX URETHRAL PROCEDURES
138	S	172	100.00	8.210	0.651	83.04	16.96	SIMPLE URETHRAL PROCEDURES
139	S	166	100.00	6.647	0.971	83.52	16.48	HEMODIALYSIS
140	S	37	100.00	1.910	0.889	97.43	2.57	PERITONEAL DIALYSIS
151	S	2731	99.93	11.479	0.485	82.79	17.21	TESTICULAR AND EPIDIDYMAL PROCEDURES
152	S	317	100.00	47.699	0.362	94.44	5.56	INSERTION OF PENILE PROSTHESIS
153	S	131	100.00	28.529	0.732	91.02	8.98	COMPLEX PENILE PROCEDURES
154	S	1371	99.85	8.537	0.607	83.43	16.57	SIMPLE PENILE PROCEDURES
155	S	5851	100.00	4.712	0.906	77.62	22.38	PROSTATE NEEDLE AND PUNCH BIOPSY
171	S	8	100.00	2.328	0.565	82.37	17.63	ARTIFICIAL FERTILIZATION
172	S	152	100.00	1.471	0.818	86.55	13.45	PROCEDURES FOR PREGNANCY AND NEONATAL CARE
173	S	42	100.00	10.823	0.426	81.72	18.28	TREATMENT OF SPONTANEOUS ABORTION
174	S	12	100.00	7.157	0.492	79.35	20.65	THERAPEUTIC ABORTION
175	S	1	100.00	1.712	0.000	85.52	14.48	VAGINAL DELIVERY
176	S	142	100.00	13.638	0.596	82.54	17.46	COMPLEX FEMALE REPRODUCTIVE PROCEDURES
177	S	1768	100.00	8.871	0.647	80.29	19.71	SIMPLE FEMALE REPRODUCTIVE PROCEDURES
178	S	4347	99.86	9.542	0.448	77.22	22.78	DILATION AND CURETTAGE
179	S	334	100.00	10.860	0.535	80.81	19.19	HYSTEROSCOPY
180	S	378	100.00	3.559	1.386	80.13	19.87	COLPOSCOPY
191	S	2987	100.00	5.919	0.493	98.83	1.17	EXTENDED EEG STUDIES
192	S	23730	98.92	1.608	0.723	91.11	8.89	ELECTROENCEPHALOGRAM
193	S	1544	99.94	2.469	0.744	85.55	14.45	ELECTROCONVULSIVE THERAPY
194	S	9271	99.85	1.265	0.927	92.57	7.43	NERVE AND MUSCLE TESTS
195	S	32848	99.67	2.372	0.759	92.22	7.78	NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP
196	S	72	100.00	21.975	1.131	93.91	6.09	REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
197	S	79	100.00	43.843	0.943	95.39	4.61	NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
198	S	11445	99.93	9.024	0.559	85.78	14.22	NERVE REPAIR AND DESTRUCTION

Relative Weights Based on Charges with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
199	S	680	100.00	3.257	0.698	57.69	42.31	SPINAL TAP
211	S	10986	99.97	1.343	0.722	96.64	3.36	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
212	S	9	100.00	1.005	0.479	97.62	2.38	FITTING OF CONTACT LENSES
213	S	76336	99.65	2.606	0.501	99.71	0.29	LASER EYE PROCEDURES
214	S	158728	99.89	17.007	0.395	93.10	6.90	CATARACT PROCEDURES
215	S	1043	100.00	24.050	0.494	90.71	9.29	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES
216	S	4944	100.00	10.588	0.706	90.17	9.83	MODERATE ANTERIOR SEGMENT EYE PROCEDURES
217	S	3357	100.00	5.889	0.970	92.38	7.62	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES
218	S	1242	100.00	18.775	0.750	90.62	9.38	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
219	S	1264	100.00	6.386	1.480	92.02	7.98	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
220	S	469	100.00	11.315	0.512	85.94	14.06	STRABISMUS AND MUSCLE EYE PROCEDURES
221	S	4039	99.98	11.418	0.587	86.59	13.41	COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE
222	S	4762	100.00	6.498	0.848	87.59	12.41	SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
223	S	1425	100.00	21.517	0.530	92.31	7.69	VITRECTOMY
231	S	3	100.00	96.768	0.680	98.01	1.99	COCHLEAR DEVICE IMPLANTATION
232	S	1702	99.77	1.546	0.546	90.27	9.73	OTORHINOLARYNGOLOGIC FUNCTION TESTS
233	S	3491	99.15	1.272	0.926	82.35	17.65	NASAL CAUTERIZATION AND PACKING
234	S	3104	100.00	13.821	0.635	84.49	15.51	COMPLEX FACIAL AND ENT PROCEDURES
235	S	6980	100.00	5.911	1.115	81.20	18.80	SIMPLE FACIAL AND ENT PROCEDURES
236	S	88	100.00	11.580	0.560	80.79	19.21	TONSIL AND ADENOID PROCEDURES
237	S	6807	99.42	0.681	0.739	96.44	3.56	SIMPLE AUDIOMETRY
251	S	2185	100.00	2.811	0.793	95.40	4.60	THERAPEUTIC NUCLEAR MEDICINE
252	S	28359	97.66	1.377	1.005	94.84	5.16	RADIATION THERAPY AND HYPERTHERMIA
253	S	12522	100.00	10.414	0.650	92.86	7.14	VASCULAR RADIOLOGY EXCEPT FOR VENOGRAPHY OF EXTREMITY
254	S	8378	99.94	5.212	0.518	86.68	13.32	MYELOGRAPHY
255	S	93564	99.66	2.188	0.600	88.61	11.39	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
271	S	5841	99.47	0.811	0.957	96.13	3.87	OCCUPATIONAL THERAPY
272	S	40807	99.15	0.996	1.287	87.66	12.34	PHYSICAL THERAPY
273	S	3771	99.26	0.843	0.938	91.31	8.69	SPEECH THERAPY
281	S	1123	100.00	1.775	1.027	97.83	2.17	NEUROPSYCHOLOGICAL TESTING
282	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
283	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
284	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
285	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
286	S	101107	99.84	1.000	1.241	65.34	34.66	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
287	S	24388	99.63	0.734	0.926	93.14	6.86	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY

Relative Weights Based on Charges with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
288	S	576	99.48	0.544	0.724	97.26	2.74	FAMILY PSYCHOTHERAPY
289	S	4101	98.80	0.576	1.283	98.83	1.17	GROUP PSYCHOTHERAPY
301	A	94595	100.00	4.082	0.436			COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
302	A	142867	99.89	2.511	0.385			INTERMEDIATE DIAGNOSTIC NUCLEAR MEDICINE
303	A	79414	99.99	1.748	0.605			SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
304	A	2635	99.89	1.159	0.429			OBSTETRICAL ULTRASOUND
305	A	380073	99.87	1.417	0.504			DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
306	A	88242	99.86	5.615	0.286			MAGNETIC RESONANCE IMAGING
307	A	535321	99.98	3.475	0.397			COMPUTERIZED AXIAL TOMOGRAPHY
308	A	488296	99.82	0.492	0.465			MAMMOGRAPHY
309	A	294620	99.87	1.141	0.381			DIGESTIVE RADIOLOGY
310	A	2648481	99.53	0.543	0.474			PLAIN FILM
311	A	25516	99.71	1.395	0.892			THERAPEUTIC RADIATION TREATMENT PREPARATION
321	A	325867	100.00	1.216	0.938			ANESTHESIA
331	A	46277	99.84	0.750	1.009			COMPLEX PATHOLOGY
332	A	645117	99.76	0.401	1.000			SIMPLE PATHOLOGY
333	A	130752	99.80	0.092	0.495			PAP SMEARS
341	A	115364	99.88	0.411	1.115			BLOOD AND TISSUE TYPING
342	A	72879	99.36	0.356	0.872			COMPLEX IMMUNOLOGY TESTS
343	A	221595	99.68	0.189	0.825			SIMPLE IMMUNOLOGY TESTS
344	A	147429	99.91	0.362	0.845			COMPLEX MICROBIOLOGY TESTS
345	A	889182	99.81	0.199	0.751			SIMPLE MICROBIOLOGY TESTS
346	A	103769	99.25	0.362	0.770			COMPLEX ENDOCRINOLOGY TESTS
347	A	684177	99.95	0.224	0.688			SIMPLE ENDOCRINOLOGY TESTS
348	A	949798	99.84	0.261	0.592			COMPLEX CHEMISTRY TESTS
349	A	1300069	99.84	0.212	0.932			SIMPLE CHEMISTRY TESTS
350	A	1492710	99.59	0.116	0.760			BASIC CHEMISTRY TESTS
351	A	2843549	99.94	0.321	0.938			MULTICHANNEL CHEMISTRY TESTS
352	A	530483	99.74	0.330	0.707			ORGAN OR DISEASE ORIENTED PANELS
353	A	39315	99.61	0.316	0.778			TOXICOLOGY TESTS
354	A	344478	99.77	0.289	0.556			THERAPEUTIC DRUG MONITORING
355	A	12254	99.42	0.253	1.045			COMPLEX CLOTTING TESTS
356	A	1324077	99.81	0.121	0.691			SIMPLE CLOTTING TESTS
357	A	1783	98.73	0.178	0.757			COMPLEX HEMATOLOGY TESTS
358	A	3780576	99.92	0.130	0.729			SIMPLE HEMATOLOGY TESTS
359	A	978656	99.95	0.101	0.687			URINALYSIS

Relative Weights Based on Charges with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
360	A	144141	99.84	0.083	0.784			BLOOD AND URINE DIPSTICK TESTS
371	A	147911	99.95	0.550	1.003			SIMPLE PULMONARY FUNCTION TESTS
372	A	146330	99.85	0.287	1.246			INFUSION THERAPY EXCEPT CHEMOTHERAPY
373	A	886469	99.27	0.405	0.550			CARDIOGRAM
374	A	116	99.15	1.126	1.571			COMPLEX IMMUNIZATION
375	A	34	100.00	0.300	0.815			MODERATE IMMUNIZATION
376	A	2577	99.77	0.326	2.033			SIMPLE IMMUNIZATION AND ALLERGY IMMUNOTHERAPY.
377	A	330	100.00	1.071	1.679			MINOR REPRODUCTIVE PROCEDURES
378	A	149576	99.98	1.421	0.644			MINOR CARDIAC AND VASCULAR TESTS
379	A	1451	99.32	1.004	0.995			MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
380	A	54591	99.28	0.295	0.490			PACEMAKER ANALYSIS
381	A	5175	100.00	1.612	1.048			TUBE CHANGE
382	A	522	100.00	2.757	0.717			PROVISION OF VISION AIDS
383	A	2095634	98.93	0.036	0.653			INTRODUCTION OF NEEDLE AND CATHETER
384	A	1596	99.25	0.351	0.951			DRESSINGS AND OTHER MINOR PROCEDURES
385	A	2831	99.79	1.216	1.412			OTHER MISCELANEOUS ANCILLARY PROCEDURES
386	A	131	98.50	0.439	0.926			BIOFEEDBACK AND OTHER TRAINING
391	A	5481	99.95	0.939	2.234			CLASS ONE CHEMOTHERAPY DRUGS
392	A	859	100.00	0.928	1.616			CLASS TWO CHEMOTHERAPY DRUGS
393	A	974	100.00	2.764	1.341			CLASS THREE CHEMOTHERAPY DRUGS
394	A	500	99.80	2.816	0.895			CLASS FOUR CHEMOTHERAPY DRUGS
395	A	312	100.00	4.993	0.580			CLASS FIVE CHEMOTHERAPY DRUGS
411	A	1218	100.00	0.329	0.940			PSYCHOTROPIC MEDICATION MANAGEMENT
412	A	87	97.75	0.650	0.905			ACTIVITY THERAPY
431	M	15504	99.86	1.430	1.574	73.25	26.75	HEMATOLOGICAL MALIGNANCY
432	M	16092	99.80	0.778	1.575	78.68	21.32	PROSTATIC MALIGNANCY
433	M	9058	99.88	1.384	1.605	62.29	37.71	LUNG MALIGNANCY
434	M	15658	99.69	0.752	1.385	57.78	42.22	BREAST MALIGNANCIES
435	M	12051	99.89	1.067	1.456	64.76	35.24	GI MALIGNANCIES
436	M	6666	99.55	0.545	1.427	65.74	34.26	SKIN MALIGNANCY
437	M	26257	99.70	0.900	1.653	69.54	30.46	OTHER MALIGNANCIES
451	M	9000	100.00	1.572	1.109	58.61	41.39	POISONING
461	M	9132	99.97	2.065	0.918	42.59	57.41	HEAD AND SPINE INJURY
462	M	59436	99.91	1.063	0.811	63.12	36.88	MINOR SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
463	M	81470	99.97	1.608	0.815	45.12	54.88	SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
464	M	124997	99.96	1.561	0.759	46.69	53.31	FRACTURE, DISLOCATION AND SPRAIN

Relative Weights Based on Charges with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
465	M	5063	99.57	0.752	0.925	89.36	10.64	BURNS
466	M	14481	99.85	1.150	1.090	68.36	31.64	OTHER INJURIES
481	M	175	100.00	0.939	1.000	47.36	52.64	NEONATE AND CONGENITAL ANOMALY
491	M	760	99.61	0.676	0.983	74.50	25.50	ROUTINE PRENATAL CARE
492	M	567	100.00	1.236	0.982	73.97	26.03	MATERNAL ANTEPARTUM COMPLICATION
493	M	74	100.00	0.621	1.057	73.80	26.20	ROUTINE POSTPARTUM CARE
494	M	175	100.00	1.261	1.092	67.06	32.94	MATERNAL POSTPARTUM COMPLICATION
501	M	4571	99.98	2.443	0.938	46.26	53.74	COMPLEX INFECTIOUS DISEASE
502	M	13598	99.94	1.403	1.008	48.84	51.16	MISCELLANEOUS INFECTIOUS DISEASES
503	M	4672	99.98	0.829	0.985	63.18	36.82	INFECTIOUS DISEASES OF GENITAL ORGANS
511	M	19205	100.00	1.858	1.129	52.12	47.88	TIA, CVA AND OTHER CEREBROVASCULAR EVENTS
512	M	31946	99.80	0.898	1.076	68.78	31.22	HEADACHE
513	M	4552	100.00	1.146	1.337	65.27	34.73	EPILEPSY
514	M	32668	100.00	2.152	0.945	50.31	49.69	NON TRAUMATIC LOSS OF CONSCIOUSNESS
515	M	34898	99.87	0.861	1.389	63.89	36.11	OTHER DISEASES OF THE NERVOUS SYSTEM
531	M	22519	99.81	0.479	1.345	86.64	13.36	CATARACTS
532	M	2875	99.83	0.366	0.753	97.59	2.41	REFRACTION DISORDER
533	M	10469	99.87	0.496	0.914	88.53	11.47	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION
534	M	83358	99.83	0.482	1.060	92.50	7.50	EYE DISEASES EXCEPT CATARACT,REFRACTION DISORDER & CONJUNCTIVITIS
541	M	2894	99.52	0.585	1.004	77.94	22.06	DENTAL DISEASE
542	M	57400	99.95	0.761	1.195	55.30	44.70	INFLUENZA, URI AND ENT INFECTIONS.
543	M	4328	99.77	0.460	1.045	89.24	10.76	HEARING LOSS
544	M	26199	99.91	1.213	0.985	64.30	35.70	OTHER COMPLEX EAR, NOSE, THROAT AND MOUTH DISEASES
545	M	30470	99.83	0.610	1.246	67.99	32.01	OTHER SIMPLE EAR, NOSE, THROAT AND MOUTH DISEASES
561	M	81662	99.97	1.246	1.134	46.29	53.71	EMPHYSEMA, CHRONIC BRONCHITIS, AND ASTHMA.
562	M	14699	99.98	1.962	0.900	43.33	56.67	PNEUMONIA
563	M	17737	99.99	2.201	0.925	45.14	54.86	COMPLEX RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
564	M	7476	99.96	1.711	0.951	41.81	58.19	SIMPLE RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
571	M	29498	99.98	2.055	1.512	51.85	48.15	CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
572	M	128082	99.87	0.653	1.217	61.13	38.87	HYPERTENSION
573	M	17118	99.58	3.534	0.582	39.05	60.95	CHEST PAIN W CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT

Relative Weights Based on Charges with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
574	M	53661	99.99	1.938	0.913	45.72	54.28	CHEST PAIN WO CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
575	M	69447	99.92	1.004	1.418	55.94	44.06	SIMPLE CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
576	M	24735	99.91	1.929	1.231	55.99	44.01	COMPLEX CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
591	M	23730	99.99	2.015	0.948	45.17	54.83	NONINFECTIOUS GASTROENTERITIS
592	M	31797	99.99	1.612	1.055	47.03	52.97	ULCERS, GASTRITIS AND ESOPHAGITIS
593	M	10231	100.00	1.743	1.194	47.92	52.08	HEPATOBILIARY DISEASE
594	M	8153	100.00	1.060	1.251	49.60	50.40	HERNIA
595	M	9689	99.89	1.025	1.166	59.80	40.20	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
596	M	6932	100.00	2.005	1.185	50.88	49.12	OTHER COMPLEX GASTROINTESTINAL DISEASES
597	M	108127	99.99	1.735	0.985	45.33	54.67	OTHER SIMPLE GASTROINTESTINAL DISEASES
611	M	15606	99.99	3.455	0.984	78.94	21.06	MAJOR SIGNS, SYMPTOMS AND FINDINGS
621	M	44345	99.98	1.192	1.069	50.35	49.65	BACK DISORDERS
622	M	28843	99.95	1.240	1.101	48.29	51.71	COMPLEX MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
623	M	132039	99.97	0.942	1.069	49.90	50.10	SIMPLE MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
631	M	8458	99.78	0.330	0.883	92.93	7.07	DISEASE OF NAILS
632	M	11576	99.31	0.727	1.255	76.63	23.37	CHRONIC SKIN ULCER
633	M	18487	99.90	0.930	1.108	65.46	34.54	CELLULITIS, IMPETIGO AND LYMPHANGITIS
634	M	6594	99.80	0.521	1.228	67.60	32.40	BREAST DISEASES
635	M	59717	99.72	0.546	1.093	77.00	23.00	SKIN DISEASES
651	M	61703	99.76	0.661	1.182	63.48	36.52	DIABETES
652	M	9924	99.88	2.074	0.988	56.53	43.47	COMPLEX ENDOCRINE,NUTRIT & METABOLIC DIS EXC DIABETES & OBESITY
653	M	21155	99.87	0.554	1.133	59.25	40.75	SIMPLE ENDOCRINE, NUTRITIONAL & METABLIC DISEASE EXC DIABETES
654	M	9330	99.97	2.975	0.901	51.45	48.55	FLUID AND ELECTROLYTE DISORDERS
661	M	42443	99.97	1.651	0.943	42.23	57.77	URINARY TRACT INFECTION
662	M	7745	99.96	1.441	1.098	54.46	45.54	RENAL FAILURE
663	M	31617	99.89	1.276	0.981	59.88	40.12	COMPLEX URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
664	M	19431	99.84	0.872	1.097	66.09	33.91	SIMPLE URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
671	M	9751	99.72	0.499	1.330	62.69	37.31	BENIGN PROSTATIC HYPERTROPHY
672	M	7715	99.87	0.733	1.186	61.14	38.86	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY

Relative Weights Based on Charges with Full Packaging (Continued)

APG Num	Type	Count Included	Percnt Included	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
681	M	14975	99.93	0.725	1.147	65.90	34.10	GYNECOLOGIC DISEASES
691	M	1965	99.85	1.036	0.962	64.01	35.99	HIV INFECTION
692	M	16127	99.99	2.053	1.054	78.13	21.87	ANEMIA
693	M	5476	99.93	2.515	1.692	85.42	14.58	OTHER COMPLEX IMMUNOLOGIC AND HEMATOLOGIC DISEASE
694	M	11298	99.68	1.127	1.498	69.03	30.97	OTHER SIMPLE IMMUNOLOGIC AND HEMATOLOGIC DISEASE
701	M	4237	99.88	0.707	1.191	62.53	37.47	ADULT MEDICAL EXAMINATION
702	M	3	100.00	0.806	1.234	58.34	41.66	WELL CHILD CARE
703	M	214	99.07	0.392	0.770	85.58	14.42	CONTRACEPTION AND PROCREATIVE MANAGEMENT
704	M	43434	99.59	0.403	1.140	74.37	25.63	AFTERCARE
705	M	102933	99.94	1.405	1.286	54.87	45.13	NONSPECIFIC SIGNS & SYMPTOMS & OTH CONTACTS W HEALTH SVCS
721	M	1356	99.93	1.687	1.174	79.30	20.70	UNKNOWN CAUSE OF MORTALITY.

Relative Weights Based on Charges with Simple Packaging

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
001	S	1118	98.50	0.235	0.855	97.43	2.57	PHOTOCHEMOTHERAPY
002	S	7515	99.95	3.510	0.938	68.83	31.17	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
003	S	597	100.00	4.852	1.191	82.82	17.18	COMPLEX INCISION AND DRAINAGE
004	S	3089	99.94	2.497	1.487	80.72	19.28	SIMPLE INCISION AND DRAINAGE
005	S	1612	99.44	0.381	0.999	92.17	7.83	NAIL PROCEDURES
006	S	11392	100.00	2.701	1.695	86.53	13.47	SIMPLE DEBRIDEMENT AND DESTRUCTION
007	S	12944	100.00	6.081	0.929	82.58	17.42	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
008	S	29900	100.00	4.612	1.014	81.54	18.46	SIMPLE EXCISION AND BIOPSY
009	S	3915	100.00	9.122	0.751	84.97	15.03	COMPLEX SKIN REPAIRS INCL INTEGUMENT GRAFTS, TRANSFER & REARRANGE
010	S	23046	99.35	1.604	0.809	70.60	29.40	SIMPLE SKIN REPAIR
011	S	12620	100.00	8.056	0.706	79.68	20.32	SIMPLE INCISION AND EXCISION OF BREAST
012	S	1154	100.00	12.352	0.642	81.76	18.24	BREAST RECONSTRUCTION AND MASTECTOMY
021	S	1294	100.00	15.209	0.622	85.65	14.35	COMPLEX MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT.
022	S	1684	99.94	9.527	0.706	83.08	16.92	SIMPLE MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
023	S	2261	100.00	12.637	0.589	84.75	15.25	COMPLEX HAND AND FOOT MUSCULOSKELETAL PROCEDURES
024	S	11801	99.97	9.102	0.652	84.99	15.01	SIMPLE HAND AND FOOT MUSCULOSKELETALPROCEDURES
025	S	6174	99.92	16.125	0.458	87.61	12.39	ARTHROSCOPY
026	S	1495	99.34	1.553	0.722	70.77	29.23	REPLACEMENT OF CAST
027	S	4265	99.74	1.258	0.788	62.80	37.20	SPLINT, STRAPPING AND CAST REMOVAL
028	S	1386	99.21	2.071	0.737	49.32	50.68	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK
029	S	6091	99.30	3.054	1.218	63.77	36.23	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK
030	S	983	100.00	14.065	0.769	81.97	18.03	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES
031	S	606	100.00	7.335	0.725	77.88	22.12	BONE OR JOINT MANIPULATION UNDER ANESTHESIA
032	S	2174	99.95	14.835	0.543	85.20	14.80	BUNION PROCEDURES
033	S	523	100.00	16.586	0.602	88.29	11.71	ARTHROPLASTY
034	S	250	100.00	7.714	0.700	85.58	14.42	HAND AND FOOT TENOTOMY
035	S	4554	99.52	1.444	1.160	79.35	20.65	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION
051	S	88896	99.97	2.735	1.005	57.70	42.30	PULMONARY TESTS
052	S	4736	99.81	3.064	0.735	66.75	33.25	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION
053	S	2704	99.96	11.992	0.531	80.46	19.54	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY

Relative Weights Based on Charges with Simple Packaging (Continued)

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
054	S	1751	100.00	4.225	1.332	80.38	19.62	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
055	S	8766	99.91	7.042	0.575	71.07	28.93	ENDOSCOPY OF THE LOWER AIRWAY
057	S	44611	99.98	2.822	0.980	57.72	42.28	RESPIRATORY THERAPY
071	S	106021	99.84	2.237	0.652	95.43	4.57	EXERCISE TOLERANCE TESTS
072	S	47977	99.66	2.548	0.603	90.79	9.21	ECHOCARDIOGRAPHY
073	S	1187	100.00	2.023	0.961	64.10	35.90	PHONOCARDIOGRAM
074	S	376	100.00	14.799	0.696	94.34	5.66	CARDIAC ELECTROPHYSIOLOGIC TESTS
075	S	3157	100.00	10.031	0.870	85.71	14.29	PLACEMENT OF TRANSVENOUS CATHETERS.
076	S	17131	99.98	19.739	0.452	94.90	5.10	DIAGNOSTIC CARDIAC CATHETERIZATION
077	S	552	100.00	13.732	0.858	92.91	7.09	ANGIOPLASTY AND TRANSCATHETER PROCEDURES
078	S	1095	100.00	55.502	0.471	96.35	3.65	PACEMAKER INSERTION AND REPLACEMENT
079	S	1133	100.00	8.661	1.355	87.81	12.19	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
080	S	7075	100.00	15.875	0.602	88.20	11.80	MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
081	S	385	100.00	6.491	1.040	89.77	10.23	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
082	S	362	100.00	13.368	0.721	86.21	13.79	VASCULAR LIGATION
083	S	3737	99.97	4.746	0.934	87.49	12.51	RESUSCITATION AND CARDIOVERSION
084	S	6761	99.30	0.752	1.420	95.79	4.21	CARDIAC REHABILITATION
091	S	2422	99.84	1.962	1.280	86.03	13.97	CHEMOTHERAPY BY EXTENDED INFUSION
092	S	2571	100.00	2.965	1.308	94.89	5.11	CHEMOTHERAPY EXCEPT BY EXTENDED INFUSION
093	S	3937	99.37	0.771	1.443	61.59	38.41	PHLEBOTOMY
094	S	557	100.00	8.219	0.915	95.01	4.99	BLOOD AND BLOOD PRODUCT EXCHANGE
095	S	2676	100.00	9.642	0.699	79.58	20.42	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
096	S	1428	100.00	1.601	1.084	59.78	40.22	ALLERGY TESTS
097	S	13802	99.73	3.842	0.686	91.77	8.23	TRANSFUSION
111	S	4086	100.00	2.884	0.818	85.80	14.20	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
112	S	4904	100.00	2.873	0.808	93.44	6.56	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
113	S	29637	99.53	1.783	0.825	92.61	7.39	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
114	S	5851	99.85	3.543	0.818	85.68	14.32	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
115	S	67274	99.85	4.178	0.565	89.59	10.41	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION
116	S	11165	99.99	4.955	0.723	91.11	8.89	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION
117	S	118467	99.82	4.823	0.514	90.49	9.51	LOWER GASTROINTESTINAL ENDOSCOPY
118	S	1397	100.00	6.757	0.798	87.49	12.51	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES
119	S	15451	99.92	14.172	0.497	86.05	13.95	HERNIA AND HYDROCELE PROCEDURES
120	S	1597	100.00	11.030	0.584	84.08	15.92	COMPLEX ANAL AND RECTAL PROCEDURES
121	S	1325	100.00	4.980	1.146	83.35	16.65	SIMPLE ANAL AND RECTAL PROCEDURES

Relative Weights Based on Charges with Simple Packaging (Continued)

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
122	S	976	100.00	8.024	0.882	87.42	12.58	MISCELLANEOUS ABDOMINAL PROCEDURES
123	S	1251	100.00	30.573	0.379	88.90	11.10	COMPLEX LAPAROSCOPIC PROCEDURES
124	S	458	100.00	16.439	0.544	85.75	14.25	SIMPLE LAPAROSCOPIC PROCEDURES
131	S	2477	100.00	34.575	0.372	96.20	3.80	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
132	S	2293	99.91	2.848	0.800	95.06	4.94	SIMPLE URINARY STUDIES AND PROCEDURES
133	S	7481	99.44	1.681	1.218	72.99	27.01	URINARY CATHETERIZATION AND DILATATION
134	S	5634	100.00	11.729	0.787	84.18	15.82	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAXY
135	S	8295	99.98	8.875	0.689	82.47	17.53	MODERATE CYSTOURETHROSCOPY
136	S	24601	99.89	4.303	0.828	86.91	13.09	SIMPLE CYSTOURETHROSCOPY
137	S	291	100.00	14.405	0.602	84.34	15.66	COMPLEX URETHRAL PROCEDURES
138	S	172	100.00	8.161	0.652	83.17	16.83	SIMPLE URETHRAL PROCEDURES
139	S	166	100.00	6.599	0.968	83.75	16.25	HEMODIALYSIS
140	S	37	100.00	1.902	0.889	97.43	2.57	PERITONEAL DIALYSIS
151	S	2731	99.93	11.415	0.485	82.89	17.11	TESTICULAR AND EPIDIDYMAL PROCEDURES
152	S	317	100.00	47.458	0.361	94.49	5.51	INSERTION OF PENILE PROSTHESIS
153	S	131	100.00	28.388	0.732	91.07	8.93	COMPLEX PENILE PROCEDURES
154	S	1371	99.85	8.490	0.607	83.52	16.48	SIMPLE PENILE PROCEDURES
155	S	5851	100.00	4.688	0.905	77.68	22.32	PROSTATE NEEDLE AND PUNCH BIOPSY
171	S	8	100.00	2.318	0.565	82.37	17.63	ARTIFICIAL FERTILIZATION
172	S	152	100.00	1.465	0.818	86.55	13.45	PROCEDURES FOR PREGNANCY AND NEONATAL CARE
173	S	42	100.00	10.771	0.426	81.75	18.25	TREATMENT OF SPONTANEOUS ABORTION
174	S	12	100.00	7.112	0.492	79.49	20.51	THERAPEUTIC ABORTION
175	S	1	100.00	1.705	0.000	85.52	14.48	VAGINAL DELIVERY
176	S	142	100.00	13.546	0.596	82.73	17.27	COMPLEX FEMALE REPRODUCTIVE PROCEDURES
177	S	1768	100.00	8.818	0.647	80.41	19.59	SIMPLE FEMALE REPRODUCTIVE PROCEDURES
178	S	4347	99.86	9.488	0.448	77.30	22.70	DILATION AND CURETTAGE
179	S	334	100.00	10.804	0.534	80.86	19.14	HYSTEROSCOPY
180	S	378	100.00	3.540	1.385	80.20	19.80	COLPOSCOPY
191	S	2987	100.00	5.886	0.494	98.95	1.05	EXTENDED EEG STUDIES
192	S	23728	98.92	1.599	0.722	91.19	8.81	ELECTROENCEPHALOGRAM
193	S	1544	99.94	2.454	0.743	85.70	14.30	ELECTROCONVULSIVE THERAPY
194	S	9271	99.85	1.257	0.926	92.75	7.25	NERVE AND MUSCLE TESTS
195	S	32848	99.67	2.360	0.759	92.25	7.75	NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP
196	S	72	100.00	21.856	1.133	94.00	6.00	REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
197	S	79	100.00	43.631	0.943	95.43	4.57	NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
198	S	11445	99.93	8.976	0.559	85.84	14.16	NERVE REPAIR AND DESTRUCTION

Relative Weights Based on Charges with Simple Packaging (Continued)

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
199	S	680	100.00	3.243	0.698	57.69	42.31	SPINAL TAP
211	S	10986	99.97	1.337	0.722	96.67	3.33	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
212	S	9	100.00	1.001	0.479	97.62	2.38	FITTING OF CONTACT LENSES
213	S	76336	99.65	2.594	0.501	99.71	0.29	LASER EYE PROCEDURES
214	S	158730	99.89	16.925	0.395	93.13	6.87	CATARACT PROCEDURES
215	S	1043	100.00	23.935	0.494	90.74	9.26	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES
216	S	4944	100.00	10.536	0.706	90.21	9.79	MODERATE ANTERIOR SEGMENT EYE PROCEDURES
217	S	3357	100.00	5.860	0.970	92.43	7.57	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES
218	S	1242	100.00	18.684	0.750	90.65	9.35	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
219	S	1264	100.00	6.355	1.480	92.06	7.94	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
220	S	469	100.00	11.255	0.511	86.01	13.99	STRABISMUS AND MUSCLE EYE PROCEDURES
221	S	4039	99.98	11.361	0.587	86.64	13.36	COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE
222	S	4762	100.00	6.467	0.848	87.62	12.38	SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
223	S	1425	100.00	21.410	0.530	92.35	7.65	VITRECTOMY
231	S	3	100.00	96.333	0.680	98.01	1.99	COCHLEAR DEVICE IMPLANTATION
232	S	1702	99.77	1.533	0.546	90.62	9.38	OTORHINOLARYNGOLOGIC FUNCTION TESTS
233	S	3490	99.12	1.262	0.921	82.42	17.58	NASAL CAUTERIZATION AND PACKING
234	S	3104	100.00	13.739	0.634	84.61	15.39	COMPLEX FACIAL AND ENT PROCEDURES
235	S	6980	100.00	5.871	1.116	81.38	18.62	SIMPLE FACIAL AND ENT PROCEDURES
236	S	88	100.00	11.507	0.560	80.94	19.06	TONSIL AND ADENOID PROCEDURES
237	S	6807	99.42	0.676	0.739	96.62	3.38	SIMPLE AUDIOMETRY
251	S	2185	100.00	2.791	0.795	95.63	4.37	THERAPEUTIC NUCLEAR MEDICINE
252	S	28359	97.66	1.371	1.006	94.86	5.14	RADIATION THERAPY AND HYPERTHERMIA
253	S	12522	100.00	10.358	0.651	92.94	7.06	VASCULAR RADIOLOGY EXCEPT FOR VENOGRAPHY OF EXTREMITY
254	S	8378	99.94	5.188	0.518	86.70	13.30	MYELOGRAPHY
255	S	93564	99.66	2.175	0.599	88.75	11.25	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
271	S	5841	99.47	0.808	0.957	96.16	3.84	OCCUPATIONAL THERAPY
272	S	40814	99.17	0.991	1.288	87.81	12.19	PHYSICAL THERAPY
273	S	3771	99.26	0.839	0.938	91.37	8.63	SPEECH THERAPY
281	S	1123	100.00	1.760	1.029	98.26	1.74	NEUROPSYCHOLOGICAL TESTING
282	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
283	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
284	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
285	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
286	S	101108	99.84	0.993	1.242	65.54	34.46	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
287	S	24379	99.60	0.722	0.926	94.12	5.88	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY

Relative Weights Based on Charges with Simple Packaging (Continued)

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
288	S	576	99.48	0.530	0.730	99.32	0.68	FAMILY PSYCHOTHERAPY
289	S	4101	98.80	0.571	1.288	99.19	0.81	GROUP PSYCHOTHERAPY
301	A	94595	100.00	4.063	0.436			COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
302	A	142867	99.89	2.500	0.385			INTERMEDIATE DIAGNOSTIC NUCLEAR MEDICINE
303	A	79414	99.99	1.740	0.605			SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
304	A	2635	99.89	1.153	0.429			OBSTETRICAL ULTRASOUND
305	A	380073	99.87	1.411	0.504			DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
306	A	88242	99.86	5.589	0.286			MAGNETIC RESONANCE IMAGING
307	A	535321	99.98	3.459	0.397			COMPUTERIZED AXIAL TOMOGRAPHY
308	A	488296	99.82	0.490	0.465			MAMMOGRAPHY
309	A	294620	99.87	1.135	0.381			DIGESTIVE RADIOLOGY
310	A	2648481	99.53	0.540	0.474			PLAIN FILM
311	A	25516	99.71	1.388	0.892			THERAPEUTIC RADIATION TREATMENT PREPARATION
321	A	325867	100.00	1.210	0.938			ANESTHESIA
331	A	46277	99.84	0.746	1.009			COMPLEX PATHOLOGY
332	A	645117	99.76	0.400	1.000			SIMPLE PATHOLOGY
333	A	130752	99.80	0.092	0.495			PAP SMEARS
341	A	115364	99.88	0.410	1.115			BLOOD AND TISSUE TYPING
342	A	72879	99.36	0.354	0.872			COMPLEX IMMUNOLOGY TESTS
343	A	221595	99.68	0.188	0.825			SIMPLE IMMUNOLOGY TESTS
344	A	147429	99.91	0.361	0.845			COMPLEX MICROBIOLOGY TESTS
345	A	889182	99.81	0.198	0.751			SIMPLE MICROBIOLOGY TESTS
346	A	103769	99.25	0.360	0.770			COMPLEX ENDOCRINOLOGY TESTS
347	A	684177	99.95	0.223	0.688			SIMPLE ENDOCRINOLOGY TESTS
348	A	949798	99.84	0.259	0.592			COMPLEX CHEMISTRY TESTS
349	A	1300069	99.84	0.211	0.932			SIMPLE CHEMISTRY TESTS
350	A	1492710	99.59	0.115	0.760			BASIC CHEMISTRY TESTS
351	A	2843549	99.94	0.319	0.938			MULTICHANNEL CHEMISTRY TESTS
352	A	530483	99.74	0.329	0.707			ORGAN OR DISEASE ORIENTED PANELS
353	A	39315	99.61	0.315	0.778			TOXICOLOGY TESTS
354	A	344478	99.77	0.287	0.556			THERAPEUTIC DRUG MONITORING
355	A	12254	99.42	0.252	1.045			COMPLEX CLOTTING TESTS
356	A	1324077	99.81	0.120	0.691			SIMPLE CLOTTING TESTS
357	A	1783	98.73	0.178	0.757			COMPLEX HEMATOLOGY TESTS
358	A	3780576	99.92	0.129	0.729			SIMPLE HEMATOLOGY TESTS
359	A	978656	99.95	0.100	0.687			URINALYSIS

Relative Weights Based on Charges with Simple Packaging (Continued)

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
360	A	144141	99.84	0.082	0.784			BLOOD AND URINE DIPSTICK TESTS
371	A	147911	99.95	0.548	1.003			SIMPLE PULMONARY FUNCTION TESTS
372	A	146330	99.85	0.285	1.246			INFUSION THERAPY EXCEPT CHEMOTHERAPY
373	A	886469	99.27	0.404	0.550			CARDIOGRAM
374	A	116	99.15	1.121	1.571			COMPLEX IMMUNIZATION
375	A	34	100.00	0.298	0.815			MODERATE IMMUNIZATION
376	A	2577	99.77	0.325	2.033			SIMPLE IMMUNIZATION AND ALLERGY IMMUNOTHERAPY.
377	A	330	100.00	1.066	1.679			MINOR REPRODUCTIVE PROCEDURES
378	A	149576	99.98	1.415	0.644			MINOR CARDIAC AND VASCULAR TESTS
379	A	1451	99.32	0.999	0.995			MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
380	A	54591	99.28	0.294	0.490			PACEMAKER ANALYSIS
381	A	5175	100.00	1.605	1.048			TUBE CHANGE
382	A	522	100.00	2.745	0.717			PROVISION OF VISION AIDS
383	A	2095634	98.93	0.036	0.653			INTRODUCTION OF NEEDLE AND CATHETER
384	A	1596	99.25	0.349	0.951			DRESSINGS AND OTHER MINOR PROCEDURES
385	A	2831	99.79	1.211	1.412			OTHER MISCELANEOUS ANCILLARY PROCEDURES
386	A	131	98.50	0.437	0.926			BIOFEEDBACK AND OTHER TRAINING
391	A	5481	99.95	0.935	2.234			CLASS ONE CHEMOTHERAPY DRUGS
392	A	859	100.00	0.924	1.616			CLASS TWO CHEMOTHERAPY DRUGS
393	A	974	100.00	2.751	1.341			CLASS THREE CHEMOTHERAPY DRUGS
394	A	500	99.80	2.803	0.895			CLASS FOUR CHEMOTHERAPY DRUGS
395	A	312	100.00	4.971	0.580			CLASS FIVE CHEMOTHERAPY DRUGS
411	A	1218	100.00	0.328	0.940			PSYCHOTROPIC MEDICATION MANAGEMENT
412	A	87	97.75	0.647	0.905			ACTIVITY THERAPY
431	M	15504	99.86	1.422	1.574	73.33	26.67	HEMATOLOGICAL MALIGNANCY
432	M	16092	99.80	0.774	1.575	78.75	21.25	PROSTATIC MALIGNANCY
433	M	9058	99.88	1.363	1.610	62.95	37.05	LUNG MALIGNANCY
434	M	15658	99.69	0.748	1.385	57.83	42.17	BREAST MALIGNANCIES
435	M	12051	99.89	1.061	1.455	64.82	35.18	GI MALIGNANCIES
436	M	6666	99.55	0.542	1.426	65.77	34.23	SKIN MALIGNANCY
437	M	26258	99.71	0.895	1.654	69.64	30.36	OTHER MALIGNANCIES
451	M	9000	100.00	1.559	1.106	58.82	41.18	POISONING
461	M	9132	99.97	2.053	0.916	42.63	57.37	HEAD AND SPINE INJURY
462	M	59436	99.91	1.058	0.811	63.14	36.86	MINOR SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
463	M	81470	99.97	1.600	0.815	45.14	54.86	SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
464	M	124998	99.96	1.554	0.758	46.71	53.29	FRACTURE, DISLOCATION AND SPRAIN

Relative Weights Based on Charges with Simple Packaging (Continued)

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
465	M	5064	99.59	0.742	0.926	90.12	9.88	BURNS
466	M	14481	99.85	1.141	1.089	68.56	31.44	OTHER INJURIES
481	M	175	100.00	0.934	1.001	47.42	52.58	NEONATE AND CONGENITAL ANOMALY
491	M	760	99.61	0.673	0.983	74.50	25.50	ROUTINE PRENATAL CARE
492	M	567	100.00	1.231	0.982	73.97	26.03	MATERNAL ANTEPARTUM COMPLICATION
493	M	74	100.00	0.618	1.057	73.80	26.20	ROUTINE POSTPARTUM CARE
494	M	175	100.00	1.255	1.092	67.06	32.94	MATERNAL POSTPARTUM COMPLICATION
501	M	4571	99.98	2.426	0.938	46.38	53.62	COMPLEX INFECTIOUS DISEASE
502	M	13598	99.94	1.394	1.007	48.93	51.07	MISCELLANEOUS INFECTIOUS DISEASES
503	M	4672	99.98	0.825	0.985	63.20	36.80	INFECTIOUS DISEASES OF GENITAL ORGANS
511	M	19205	100.00	1.845	1.125	52.26	47.74	TIA, CVA AND OTHER CEREBROVASCULAR EVENTS
512	M	31946	99.80	0.893	1.075	68.85	31.15	HEADACHE
513	M	4552	100.00	1.139	1.331	65.39	34.61	EPILEPSY
514	M	32668	100.00	2.136	0.942	50.46	49.54	NON TRAUMATIC LOSS OF CONSCIOUSNESS
515	M	34898	99.87	0.856	1.388	63.98	36.02	OTHER DISEASES OF THE NERVOUS SYSTEM
531	M	22519	99.81	0.477	1.346	86.67	13.33	CATARACTS
532	M	2877	99.90	0.365	0.754	97.49	2.51	REFRACTION DISORDER
533	M	10469	99.87	0.493	0.914	88.60	11.40	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION
534	M	83358	99.83	0.479	1.060	92.55	7.45	EYE DISEASES EXCEPT CATARACT,REFRACTION DISORDER & CONJUNCTIVITIS
541	M	2894	99.52	0.582	1.004	77.94	22.06	DENTAL DISEASE
542	M	57401	99.95	0.756	1.194	55.45	44.55	INFLUENZA, URI AND ENT INFECTIONS.
543	M	4328	99.77	0.456	1.047	89.64	10.36	HEARING LOSS
544	M	26200	99.91	1.206	0.984	64.37	35.63	OTHER COMPLEX EAR, NOSE, THROAT AND MOUTH DISEASES
545	M	30474	99.85	0.600	1.250	68.86	31.14	OTHER SIMPLE EAR, NOSE, THROAT AND MOUTH DISEASES
561	M	81665	99.98	1.214	1.131	47.34	52.66	EMPHYSEMA, CHRONIC BRONCHITIS, AND ASTHMA.
562	M	14699	99.98	1.938	0.895	43.66	56.34	PNEUMONIA
563	M	17737	99.99	2.151	0.924	45.97	54.03	COMPLEX RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
564	M	7476	99.96	1.664	0.953	42.79	57.21	SIMPLE RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
571	M	29498	99.98	2.032	1.509	52.20	47.80	CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
572	M	128082	99.87	0.649	1.215	61.22	38.78	HYPERTENSION
573	M	17120	99.59	3.505	0.581	39.22	60.78	CHEST PAIN W CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT

Relative Weights Based on Charges with Simple Packaging (Continued)

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
574	M	53661	99.99	1.922	0.911	45.90	54.10	CHEST PAIN WO CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
575	M	69445	99.92	0.996	1.414	56.10	43.90	SIMPLE CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
576	M	24735	99.91	1.914	1.230	56.18	43.82	COMPLEX CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
591	M	23730	99.99	2.004	0.947	45.22	54.78	NONINFECTIOUS GASTROENTERITIS
592	M	31797	99.99	1.603	1.054	47.10	52.90	ULCERS, GASTRITIS AND ESOPHAGITIS
593	M	10231	100.00	1.733	1.193	47.97	52.03	HEPATOBILIARY DISEASE
594	M	8153	100.00	1.054	1.250	49.66	50.34	HERNIA
595	M	9689	99.89	1.019	1.164	59.87	40.13	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
596	M	6932	100.00	1.994	1.182	50.93	49.07	OTHER COMPLEX GASTROINTESTINAL DISEASES
597	M	108128	99.99	1.726	0.985	45.38	54.62	OTHER SIMPLE GASTROINTESTINAL DISEASES
611	M	15606	99.99	3.374	0.983	80.46	19.54	MAJOR SIGNS, SYMPTOMS AND FINDINGS
621	M	44345	99.98	1.186	1.068	50.39	49.61	BACK DISORDERS
622	M	28843	99.95	1.232	1.101	48.36	51.64	COMPLEX MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
623	M	132038	99.97	0.937	1.067	49.94	50.06	SIMPLE MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
631	M	8458	99.78	0.328	0.883	92.95	7.05	DISEASE OF NAILS
632	M	11576	99.31	0.722	1.255	76.78	23.22	CHRONIC SKIN ULCER
633	M	18487	99.90	0.925	1.107	65.50	34.50	CELLULITIS, IMPETIGO AND LYMPHANGITIS
634	M	6594	99.80	0.517	1.226	67.79	32.21	BREAST DISEASES
635	M	59721	99.73	0.543	1.093	77.07	22.93	SKIN DISEASES
651	M	61707	99.76	0.658	1.182	63.57	36.43	DIABETES
652	M	9924	99.88	2.059	0.988	56.69	43.31	COMPLEX ENDOCRINE,NUTRIT & METABOLIC DIS EXC DIABETES & OBESITY
653	M	21156	99.88	0.550	1.131	59.37	40.63	SIMPLE ENDOCRINE, NUTRITIONAL & METABLIC DISEASE EXC DIABETES
654	M	9330	99.97	2.954	0.900	51.59	48.41	FLUID AND ELECTROLYTE DISORDERS
661	M	42443	99.97	1.642	0.942	42.27	57.73	URINARY TRACT INFECTION
662	M	7745	99.96	1.431	1.096	54.61	45.39	RENAL FAILURE
663	M	31617	99.89	1.269	0.981	59.92	40.08	COMPLEX URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
664	M	19431	99.84	0.865	1.098	66.32	33.68	SIMPLE URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
671	M	9750	99.71	0.489	1.335	63.56	36.44	BENIGN PROSTATIC HYPERTROPHY

Relative Weights Based on Charges with Simple Packaging (Continued)

APG Num	Type	Count Included	Percent Incl.	Weight	CV	Percent Direct	Percent Pack.	APG Description
672	M	7715	99.87	0.728	1.186	61.28	38.72	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY
681	M	14974	99.93	0.720	1.144	65.99	34.01	GYNECOLOGIC DISEASES
691	M	1965	99.85	1.029	0.961	64.16	35.84	HIV INFECTION
692	M	16127	99.99	2.042	1.054	78.18	21.82	ANEMIA
693	M	5476	99.93	2.501	1.694	85.49	14.51	OTHER COMPLEX IMMUNOLOGIC AND HEMATOLOGIC DISEASE
694	M	11297	99.67	1.119	1.492	69.09	30.91	OTHER SIMPLE IMMUNOLOGIC AND HEMATOLOGIC DISEASE
701	M	4237	99.88	0.701	1.191	62.78	37.22	ADULT MEDICAL EXAMINATION
702	M	3	100.00	0.803	1.234	58.34	41.66	WELL CHILD CARE
703	M	214	99.07	0.390	0.770	85.58	14.42	CONTRACEPTION AND PROCREATIVE MANAGEMENT
704	M	43435	99.59	0.401	1.138	74.47	25.53	AFTERCARE
705	M	102933	99.94	1.396	1.286	54.98	45.02	NONSPECIFIC SIGNS & SYMPTOMS & OTH CONTACTS W HEALTH SVCS
721	M	1356	99.93	1.663	1.169	80.09	19.91	UNKNOWN CAUSE OF MORTALITY.

Relative Weights Based on Charges with Limited Packaging

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
001	S	1119	98.59	0.167	0.766	99.91	0.09	PHOTOCHEMOTHERAPY
002	S	7514	99.93	1.801	1.114	97.81	2.19	SUPERFICIAL NEEDLE BIOPSY AND ASPIRATION
003	S	597	100.00	3.149	1.233	93.23	6.77	COMPLEX INCISION AND DRAINAGE
004	S	3090	99.97	1.547	1.623	95.68	4.32	SIMPLE INCISION AND DRAINAGE
005	S	1610	99.32	0.255	0.905	99.88	0.12	NAIL PROCEDURES
006	S	11392	100.00	1.792	1.714	95.29	4.71	SIMPLE DEBRIDEMENT AND DESTRUCTION
007	S	12944	100.00	3.921	0.946	93.56	6.44	COMPLEX EXCISION, BIOPSY AND DEBRIDEMENT
008	S	29900	100.00	2.907	1.061	94.54	5.46	SIMPLE EXCISION AND BIOPSY
009	S	3915	100.00	6.135	0.764	92.31	7.69	COMPLEX SKIN REPAIRS INCL INTEGUMENT GRAFTS, TRANSFER & REARRANGE
010	S	22919	98.80	0.806	0.599	99.44	0.56	SIMPLE SKIN REPAIR
011	S	12620	100.00	5.096	0.730	92.03	7.97	SIMPLE INCISION AND EXCISION OF BREAST
012	S	1154	100.00	8.059	0.678	91.56	8.44	BREAST RECONSTRUCTION AND MASTECTOMY
021	S	1294	100.00	10.328	0.643	92.16	7.84	COMPLEX MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT.
022	S	1685	100.00	6.334	0.766	91.95	8.05	SIMPLE MUSCULOSKELETAL PROCEDURES EXCLUDING HAND AND FOOT
023	S	2261	100.00	8.555	0.601	91.47	8.53	COMPLEX HAND AND FOOT MUSCULOSKELETAL PROCEDURES
024	S	11801	99.97	6.114	0.650	92.44	7.56	SIMPLE HAND AND FOOT MUSCULOSKELETAL PROCEDURES
025	S	6176	99.95	11.124	0.467	92.86	7.14	ARTHROSCOPY
026	S	1489	98.94	0.785	0.696	99.89	0.11	REPLACEMENT OF CAST
027	S	4246	99.30	0.562	0.685	99.80	0.20	SPLINT, STRAPPING AND CAST REMOVAL
028	S	1381	98.85	0.735	0.934	98.75	1.25	CLOSED TREATMENT FX & DISLOCATION OF FINGER, TOE & TRUNK
029	S	6073	99.01	1.456	1.521	94.91	5.09	CLOSED TREATMENT FX & DISLOCATION EXC FINGER, TOE & TRUNK
030	S	983	100.00	9.078	0.811	92.79	7.21	OPEN OR PERCUTANEOUS TREATMENT OF FRACTURES
031	S	606	100.00	4.652	0.761	89.72	10.28	BONE OR JOINT MANIPULATION UNDER ANESTHESIA
032	S	2174	99.95	10.041	0.552	91.98	8.02	BUNION PROCEDURES
033	S	523	100.00	11.393	0.620	93.91	6.09	ARTHROPLASTY
034	S	250	100.00	5.232	0.681	92.19	7.81	HAND AND FOOT TENOTOMY
035	S	4551	99.45	0.857	1.180	96.99	3.01	ARTHROCENTESIS AND LIGAMENT OR TENDON INJECTION
051	S	88795	99.86	1.143	1.201	98.89	1.11	PULMONARY TESTS
052	S	4726	99.60	1.487	0.771	99.29	0.71	NEEDLE AND CATHETER BIOPSY, ASPIRATION, LAVAGE AND INTUBATION
053	S	2705	100.00	7.838	0.562	90.10	9.90	COMPLEX ENDOSCOPY OF THE UPPER AIRWAY

Relative Weights Based on Charges with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
054	S	1751	100.00	2.711	1.362	91.53	8.47	SIMPLE ENDOSCOPY OF THE UPPER AIRWAY
055	S	8761	99.85	3.775	0.632	96.63	3.37	ENDOSCOPY OF THE LOWER AIRWAY
057	S	44544	99.83	1.178	1.154	98.85	1.15	RESPIRATORY THERAPY
071	S	106077	99.90	1.564	0.659	99.92	0.08	EXERCISE TOLERANCE TESTS
072	S	48056	99.83	1.702	0.586	99.87	0.13	ECHOCARDIOGRAPHY
073	S	1187	100.00	0.953	0.996	99.37	0.63	PHONOCARDIOGRAM
074	S	376	100.00	10.275	0.704	99.28	0.72	CARDIAC ELECTROPHYSIOLOGIC TESTS
075	S	3157	100.00	6.534	0.916	96.15	3.85	PLACEMENT OF TRANSVENOUS CATHETERS.
076	S	17131	99.98	13.702	0.457	99.90	0.10	DIAGNOSTIC CARDIAC CATHETERIZATION
077	S	552	100.00	9.386	0.882	99.32	0.68	ANGIOPLASTY AND TRANSCATHETER PROCEDURES
078	S	1095	100.00	39.480	0.474	98.97	1.03	PACEMAKER INSERTION AND REPLACEMENT
079	S	1133	100.00	5.868	1.399	94.70	5.30	REMOVAL AND REVISION OF PACEMAKER AND VASCULAR DEVICE
080	S	7075	100.00	10.838	0.615	94.40	5.60	MINOR VASCULAR REPAIR AND FISTULA CONSTRUCTION
081	S	385	100.00	4.426	1.054	96.20	3.80	SECONDARY VARICOSE VEINS AND VASCULAR INJECTION
082	S	362	100.00	9.127	0.729	92.26	7.74	VASCULAR LIGATION
083	S	3736	99.95	3.051	0.930	99.09	0.91	RESUSCITATION AND CARDIOVERSION
084	S	6752	99.16	0.519	1.405	99.92	0.08	CARDIAC REHABILITATION
091	S	2422	99.84	1.242	1.448	99.29	0.71	CHEMOTHERAPY BY EXTENDED INFUSION
092	S	2571	100.00	2.064	1.363	99.60	0.40	CHEMOTHERAPY EXCEPT BY EXTENDED INFUSION
093	S	3951	99.72	0.377	1.845	98.18	1.82	PHLEBOTOMY
094	S	557	100.00	5.720	0.929	99.76	0.24	BLOOD AND BLOOD PRODUCT EXCHANGE
095	S	2676	100.00	6.087	0.745	92.10	7.90	DEEP LYMPH STRUCTURE AND THYROID PROCEDURES
096	S	1425	99.79	0.681	1.114	99.41	0.59	ALLERGY TESTS
097	S	13807	99.76	2.589	0.694	99.63	0.37	TRANSFUSION
111	S	4086	100.00	1.811	0.852	99.82	0.18	ALIMENTARY TESTS AND SIMPLE TUBE PLACEMENT
112	S	4904	100.00	1.979	0.798	99.12	0.88	ESOPHAGEAL DILATION WITHOUT ENDOSCOPY
113	S	29657	99.59	1.220	0.818	99.18	0.82	ANOSCOPY WITH BIOPSY AND DIAGNOSTIC PROCTOSIGMOIDOSCOPY
114	S	5854	99.90	2.268	0.882	98.12	1.88	PROCTOSIGMOIDOSCOPY WITH EXCISION OR BIOPSY
115	S	67279	99.86	2.769	0.558	98.75	1.25	DIAGNOSTIC UPPER GI ENDOSCOPY OR INTUBATION
116	S	11165	99.99	3.350	0.726	98.47	1.53	THERAPEUTIC UPPER GI ENDOSCOPY OR INTUBATION
117	S	118472	99.83	3.229	0.501	98.72	1.28	LOWER GASTROINTESTINAL ENDOSCOPY
118	S	1397	100.00	4.354	0.838	99.21	0.79	ERCP AND MISCELLANEOUS GI ENDOSCOPY PROCEDURES
119	S	15447	99.90	9.678	0.504	92.00	8.00	HERNIA AND HYDROCELE PROCEDURES

Relative Weights Based on Charges with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
120	S	1597	100.00	7.363	0.592	92.03	7.97	COMPLEX ANAL AND RECTAL PROCEDURES
121	S	1325	100.00	3.264	1.182	92.92	7.08	SIMPLE ANAL AND RECTAL PROCEDURES
122	S	976	100.00	5.445	0.890	94.12	5.88	MISCELLANEOUS ABDOMINAL PROCEDURES
123	S	1251	100.00	21.152	0.383	93.88	6.12	COMPLEX LAPAROSCOPIC PROCEDURES
124	S	458	100.00	11.162	0.556	92.27	7.73	SIMPLE LAPAROSCOPIC PROCEDURES
131	S	2477	100.00	24.645	0.371	98.61	1.39	RENAL EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY
132	S	2294	99.96	2.004	0.793	98.94	1.06	SIMPLE URINARY STUDIES AND PROCEDURES
133	S	7420	98.63	0.848	1.203	98.21	1.79	URINARY CATHETERIZATION AND DILATATION
134	S	5634	100.00	7.784	0.817	92.68	7.32	COMPLEX CYSTOURETHROSCOPY AND LITHOLAPAXY
135	S	8295	99.98	5.812	0.696	92.02	7.98	MODERATE CYSTOURETHROSCOPY
136	S	24604	99.90	2.899	0.818	94.33	5.67	SIMPLE CYSTOURETHROSCOPY
137	S	291	100.00	9.647	0.617	92.02	7.98	COMPLEX URETHRAL PROCEDURES
138	S	172	100.00	5.366	0.659	92.42	7.58	SIMPLE URETHRAL PROCEDURES
139	S	166	100.00	4.044	1.013	99.85	0.15	HEMODIALYSIS
140	S	37	100.00	1.354	0.864	100.00	0.00	PERITONEAL DIALYSIS
151	S	2731	99.93	7.559	0.494	91.46	8.54	TESTICULAR AND EPIDIDYMAL PROCEDURES
152	S	317	100.00	33.611	0.365	97.48	2.52	INSERTION OF PENILE PROSTHESIS
153	S	131	100.00	19.770	0.751	95.55	4.45	COMPLEX PENILE PROCEDURES
154	S	1371	99.85	5.622	0.604	92.16	7.84	SIMPLE PENILE PROCEDURES
155	S	5851	100.00	2.849	0.977	93.39	6.61	PROSTATE NEEDLE AND PUNCH BIOPSY
171	S	8	100.00	1.396	0.453	99.88	0.12	ARTIFICIAL FERTILIZATION
172	S	152	100.00	0.928	0.736	99.77	0.23	PROCEDURES FOR PREGNANCY AND NEONATAL CARE
173	S	42	100.00	7.164	0.440	89.81	10.19	TREATMENT OF SPONTANEOUS ABORTION
174	S	12	100.00	4.605	0.471	89.70	10.30	THERAPEUTIC ABORTION
175	S	1	100.00	1.079	0.000	98.76	1.24	VAGINAL DELIVERY
176	S	142	100.00	8.929	0.621	91.70	8.30	COMPLEX FEMALE REPRODUCTIVE PROCEDURES
177	S	1768	100.00	5.738	0.666	90.29	9.71	SIMPLE FEMALE REPRODUCTIVE PROCEDURES
178	S	4348	99.89	6.035	0.462	88.85	11.15	DILATION AND CURETTAGE
179	S	334	100.00	7.109	0.575	89.80	10.20	HYSTEROSCOPY
180	S	378	100.00	2.207	1.488	93.99	6.01	COLPOSCOPY
191	S	2987	100.00	4.256	0.499	99.99	0.01	EXTENDED EEG STUDIES
192	S	23750	99.01	1.067	0.654	99.80	0.20	ELECTROENCEPHALOGRAM
193	S	1544	99.94	1.757	0.734	87.48	12.52	ELECTROCONVULSIVE THERAPY

Relative Weights Based on Charges with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
194	S	9269	99.83	0.850	0.919	99.92	0.08	NERVE AND MUSCLE TESTS
195	S	32854	99.68	1.665	0.744	95.58	4.42	NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP
196	S	72	100.00	15.502	1.156	96.83	3.17	REVISION AND REMOVAL OF NEUROLOGICAL DEVICE
197	S	79	100.00	31.029	0.973	98.04	1.96	NEUROSTIMULATOR AND VENTRICULAR SHUNT IMPLANTATION
198	S	11443	99.91	6.131	0.551	91.76	8.24	NERVE REPAIR AND DESTRUCTION
199	S	677	99.56	1.341	0.762	98.86	1.14	SPINAL TAP
211	S	10987	99.98	0.945	0.679	99.95	0.05	MINOR OPHTHALMOLOGICAL TESTS AND PROCEDURES
212	S	9	100.00	0.714	0.532	100.00	0.00	FITTING OF CONTACT LENSES
213	S	76346	99.66	1.894	0.501	99.85	0.15	LASER EYE PROCEDURES
214	S	158729	99.89	12.039	0.394	95.66	4.34	CATARACT PROCEDURES
215	S	1043	100.00	16.649	0.499	95.31	4.69	COMPLEX ANTERIOR SEGMENT EYE PROCEDURES
216	S	4944	100.00	7.399	0.702	93.86	6.14	MODERATE ANTERIOR SEGMENT EYE PROCEDURES
217	S	3357	100.00	4.137	0.954	95.65	4.35	SIMPLE ANTERIOR SEGMENT EYE PROCEDURES
218	S	1242	100.00	13.103	0.754	94.45	5.55	COMPLEX POSTERIOR SEGMENT EYE PROCEDURES
219	S	1264	100.00	4.463	1.474	95.77	4.23	SIMPLE POSTERIOR SEGMENT EYE PROCEDURES
220	S	469	100.00	7.816	0.513	90.50	9.50	STRABISMUS AND MUSCLE EYE PROCEDURES
221	S	4039	99.98	7.810	0.592	92.08	7.92	COMPLEX REPAIR AND PLASTIC PROCEDURES OF EYE
222	S	4762	100.00	4.426	0.848	93.54	6.46	SIMPLE REPAIR AND PLASTIC PROCEDURES OF EYE
223	S	1425	100.00	15.107	0.530	95.63	4.37	VITRECTOMY
231	S	3	100.00	70.254	0.680	98.20	1.80	COCHLEAR DEVICE IMPLANTATION
232	S	1703	99.82	1.017	0.538	99.83	0.17	OTORHINOLARYNGOLOGIC FUNCTION TESTS
233	S	3476	98.72	0.747	0.844	99.06	0.94	NASAL CAUTERIZATION AND PACKING
234	S	3104	100.00	9.292	0.654	91.42	8.58	COMPLEX FACIAL AND ENT PROCEDURES
235	S	6979	99.99	3.792	1.138	91.74	8.26	SIMPLE FACIAL AND ENT PROCEDURES
236	S	88	100.00	7.503	0.560	90.71	9.29	TONSIL AND ADENOID PROCEDURES
237	S	6808	99.43	0.477	0.721	99.93	0.07	SIMPLE AUDIOMETRY
251	S	2185	100.00	1.951	0.817	99.97	0.03	THERAPEUTIC NUCLEAR MEDICINE
252	S	28357	97.65	0.950	0.979	99.86	0.14	RADIATION THERAPY AND HYPERTHERMIA
253	S	12522	100.00	7.059	0.658	99.64	0.36	VASCULAR RADIOLOGY EXCEPT FOR VENOGRAPHY OF EXTREMITY
254	S	8378	99.94	3.293	0.507	99.79	0.21	MYELOGRAPHY
255	S	93600	99.70	1.414	0.548	99.74	0.26	MISCELLANEOUS RADIOLOGICAL PROCEDURES WITH CONTRAST
271	S	5839	99.44	0.565	0.934	99.93	0.07	OCCUPATIONAL THERAPY
272	S	40748	99.01	0.625	1.210	99.80	0.20	PHYSICAL THERAPY

Relative Weights Based on Charges with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
273	S	3753	98.79	0.544	0.840	99.98	0.02	SPEECH THERAPY
281	S	1123	100.00	1.264	1.010	99.98	0.02	NEUROPSYCHOLOGICAL TESTING
282	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
283	S	0	0.00	0.000	0.000	0.00	0.00	FULL DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
284	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR SUBSTANCE ABUSE
285	S	0	0.00	0.000	0.000	0.00	0.00	HALF DAY PARTIAL HOSPITALIZATION FOR MENTAL ILLNESS
286	S	100731	99.47	0.461	0.987	99.15	0.85	COUNSELLING OR INDIVIDUAL BRIEF PSYCHOTHERAPY
287	S	24408	99.71	0.499	0.855	99.82	0.18	INDIVIDUAL COMPREHENSIVE PSYCHOTHERAPY
288	S	579	100.00	0.393	0.765	99.98	0.02	FAMILY PSYCHOTHERAPY
289	S	4101	98.80	0.414	1.293	99.95	0.05	GROUP PSYCHOTHERAPY
301	A	94595	100.00	2.969	0.436			COMPLEX DIAGNOSTIC NUCLEAR MEDICINE
302	A	142867	99.89	1.827	0.385			INTERMEDIATE DIAGNOSTIC NUCLEAR MEDICINE
303	A	79414	99.99	1.272	0.605			SIMPLE DIAGNOSTIC NUCLEAR MEDICINE
304	A	2635	99.89	0.843	0.429			OBSTETRICAL ULTRASOUND
305	A	380073	99.87	1.031	0.504			DIAGNOSTIC ULTRASOUND EXCEPT OBSTETRICAL
306	A	88242	99.86	4.084	0.286			MAGNETIC RESONANCE IMAGING
307	A	535321	99.98	2.528	0.397			COMPUTERIZED AXIAL TOMOGRAPHY
308	A	488296	99.82	0.358	0.465			MAMMOGRAPHY
309	A	294620	99.87	0.830	0.381			DIGESTIVE RADIOLOGY
310	A	2648481	99.53	0.395	0.474			PLAIN FILM
311	A	25516	99.71	1.014	0.892			THERAPEUTIC RADIATION TREATMENT PREPARATION
321	A	325867	100.00	0.884	0.938			ANESTHESIA
331	A	46277	99.84	0.545	1.009			COMPLEX PATHOLOGY
332	A	645117	99.76	0.292	1.000			SIMPLE PATHOLOGY
333	A	130752	99.80	0.067	0.495			PAP SMEARS
341	A	115364	99.88	0.299	1.115			BLOOD AND TISSUE TYPING
342	A	72879	99.36	0.259	0.872			COMPLEX IMMUNOLOGY TESTS
343	A	221595	99.68	0.137	0.825			SIMPLE IMMUNOLOGY TESTS
344	A	147429	99.91	0.264	0.845			COMPLEX MICROBIOLOGY TESTS
345	A	889182	99.81	0.145	0.751			SIMPLE MICROBIOLOGY TESTS
346	A	103769	99.25	0.263	0.770			COMPLEX ENDOCRINOLOGY TESTS
347	A	684177	99.95	0.163	0.688			SIMPLE ENDOCRINOLOGY TESTS
348	A	949798	99.84	0.190	0.592			COMPLEX CHEMISTRY TESTS

Relative Weights Based on Charges with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
349	A	1300069	99.84	0.154	0.932			SIMPLE CHEMISTRY TESTS
350	A	1492710	99.59	0.084	0.760			BASIC CHEMISTRY TESTS
351	A	2843549	99.94	0.233	0.938			MULTICHANNEL CHEMISTRY TESTS
352	A	530483	99.74	0.240	0.707			ORGAN OR DISEASE ORIENTED PANELS
353	A	39315	99.61	0.230	0.778			TOXICOLOGY TESTS
354	A	344478	99.77	0.210	0.556			THERAPEUTIC DRUG MONITORING
355	A	12254	99.42	0.184	1.045			COMPLEX CLOTTING TESTS
356	A	1324077	99.81	0.088	0.691			SIMPLE CLOTTING TESTS
357	A	1783	98.73	0.130	0.757			COMPLEX HEMATOLOGY TESTS
358	A	3780576	99.92	0.095	0.729			SIMPLE HEMATOLOGY TESTS
359	A	978656	99.95	0.073	0.687			URINALYSIS
360	A	144141	99.84	0.060	0.784			BLOOD AND URINE DIPSTICK TESTS
371	A	147911	99.95	0.400	1.003			SIMPLE PULMONARY FUNCTION TESTS
372	A	146330	99.85	0.209	1.246			INFUSION THERAPY EXCEPT CHEMOTHERAPY
373	A	886469	99.27	0.295	0.550			CARDIOGRAM
374	A	116	99.15	0.819	1.571			COMPLEX IMMUNIZATION
375	A	34	100.00	0.218	0.815			MODERATE IMMUNIZATION
376	A	2577	99.77	0.237	2.033			SIMPLE IMMUNIZATION AND ALLERGY IMMUNOTHERAPY.
377	A	330	100.00	0.779	1.679			MINOR REPRODUCTIVE PROCEDURES
378	A	149576	99.98	1.034	0.644			MINOR CARDIAC AND VASCULAR TESTS
379	A	1451	99.32	0.730	0.995			MINOR OPHTHALMOLOGICAL INJECTION, SCRAPING AND TESTS
380	A	54591	99.28	0.215	0.490			PACEMAKER ANALYSIS
381	A	5175	100.00	1.172	1.048			TUBE CHANGE
382	A	522	100.00	2.006	0.717			PROVISION OF VISION AIDS
383	A	2095634	98.93	0.026	0.653			INTRODUCTION OF NEEDLE AND CATHETER
384	A	1596	99.25	0.255	0.951			DRESSINGS AND OTHER MINOR PROCEDURES
385	A	2831	99.79	0.885	1.412			OTHER MISCELANEOUS ANCILLARY PROCEDURES
386	A	131	98.50	0.319	0.926			BIOFEEDBACK AND OTHER TRAINING
391	A	5481	99.95	0.683	2.234			CLASS ONE CHEMOTHERAPY DRUGS
392	A	859	100.00	0.675	1.616			CLASS TWO CHEMOTHERAPY DRUGS
393	A	974	100.00	2.010	1.341			CLASS THREE CHEMOTHERAPY DRUGS
394	A	500	99.80	2.048	0.895			CLASS FOUR CHEMOTHERAPY DRUGS
395	A	312	100.00	3.632	0.580			CLASS FIVE CHEMOTHERAPY DRUGS

Relative Weights Based on Charges with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
411	A	1218	100.00	0.239	0.940			PSYCHOTROPIC MEDICATION MANAGEMENT
412	A	87	97.75	0.473	0.905			ACTIVITY THERAPY
431	M	15466	99.62	0.736	1.887	98.91	1.09	HEMATOLOGICAL MALIGNANCY
432	M	16048	99.52	0.434	1.742	98.98	1.02	PROSTATIC MALIGNANCY
433	M	8998	99.22	0.551	1.781	99.13	0.87	LUNG MALIGNANCY
434	M	15420	98.18	0.261	1.287	98.38	1.62	BREAST MALIGNANCIES
435	M	11978	99.29	0.459	1.530	98.87	1.13	GI MALIGNANCIES
436	M	6608	98.69	0.238	1.154	99.34	0.66	SKIN MALIGNANCY
437	M	26050	98.92	0.401	1.611	99.19	0.81	OTHER MALIGNANCIES
451	M	8979	99.77	0.661	1.080	98.91	1.09	POISONING
461	M	9089	99.50	0.611	1.017	99.48	0.52	HEAD AND SPINE INJURY
462	M	59362	99.78	0.484	0.733	99.83	0.17	MINOR SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
463	M	81256	99.70	0.519	0.758	99.66	0.34	SKIN AND SOFT TISSUE INJURIES EXCEPT BURNS
464	M	124765	99.77	0.523	0.791	99.76	0.24	FRACTURE, DISLOCATION AND SPRAIN
465	M	5071	99.72	0.493	0.835	99.86	0.14	BURNS
466	M	14431	99.50	0.555	1.010	99.57	0.43	OTHER INJURIES
481	M	175	100.00	0.326	0.781	99.31	0.69	NEONATE AND CONGENITAL ANOMALY
491	M	761	99.74	0.372	0.936	99.10	0.90	ROUTINE PRENATAL CARE
492	M	565	99.65	0.645	0.961	99.43	0.57	MATERNAL ANTEPARTUM COMPLICATION
493	M	74	100.00	0.336	1.024	99.25	0.75	ROUTINE POSTPARTUM CARE
494	M	175	100.00	0.624	1.152	98.46	1.54	MATERNAL POSTPARTUM COMPLICATION
501	M	4555	99.63	0.800	1.125	98.21	1.79	COMPLEX INFECTIOUS DISEASE
502	M	13541	99.52	0.481	0.919	98.58	1.42	MISCELLANEOUS INFECTIOUS DISEASES
503	M	4670	99.94	0.382	0.769	99.20	0.80	INFECTIOUS DISEASES OF GENITAL ORGANS
511	M	19193	99.94	0.703	1.289	98.89	1.11	TIA, CVA AND OTHER CEREBROVASCULAR EVENTS
512	M	31870	99.56	0.444	0.808	99.33	0.67	HEADACHE
513	M	4546	99.87	0.542	1.236	98.41	1.59	EPILEPSY
514	M	32646	99.93	0.791	1.064	98.69	1.31	NON TRAUMATIC LOSS OF CONSCIOUSNESS
515	M	34715	99.34	0.376	1.152	99.12	0.88	OTHER DISEASES OF THE NERVOUS SYSTEM
531	M	22509	99.77	0.301	1.339	99.67	0.33	CATARACTS
532	M	2879	99.97	0.261	0.730	99.89	0.11	REFRACTION DISORDER
533	M	10475	99.92	0.320	0.770	99.81	0.19	CONJUNCTIVITIS AND OTHER SIMPLE EXTERNAL EYE INFLAMMATION

Relative Weights Based on Charges with Limited Packaging (Continued)

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
534	M	83367	99.84	0.325	0.992	99.83	0.17	EYE DISEASES EXCEPT CATARACT, REFRACTION DISORDER & CONJUNCTIVITIS
541	M	2896	99.59	0.331	0.784	99.57	0.43	DENTAL DISEASE
542	M	57240	99.67	0.301	0.846	99.01	0.99	INFLUENZA, URI AND ENT INFECTIONS.
543	M	4332	99.86	0.300	0.949	99.78	0.22	HEARING LOSS
544	M	26132	99.65	0.560	0.881	98.93	1.07	OTHER COMPLEX EAR, NOSE, THROAT AND MOUTH DISEASES
545	M	30443	99.74	0.300	0.965	99.33	0.67	OTHER SIMPLE EAR, NOSE, THROAT AND MOUTH DISEASES
561	M	81450	99.71	0.411	1.056	98.59	1.41	EMPHYSEMA, CHRONIC BRONCHITIS, AND ASTHMA.
562	M	14667	99.76	0.611	1.049	98.41	1.59	PNEUMONIA
563	M	17717	99.88	0.719	1.095	98.78	1.22	COMPLEX RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
564	M	7466	99.83	0.519	1.092	98.48	1.52	SIMPLE RESPIRATORY DIS EXC EMPHYSEMA,CHR BRONCHITIS & ASTHMA
571	M	29319	99.37	0.669	1.403	98.62	1.38	CONGESTIVE HEART FAILURE AND ISCHEMIC HEART DISEASE
572	M	127785	99.64	0.287	0.886	98.68	1.32	HYPERTENSION
573	M	17138	99.70	1.022	0.917	98.48	1.52	CHEST PAIN W CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
574	M	53592	99.86	0.638	1.026	98.99	1.01	CHEST PAIN WO CARDIAC ENZYMES TO RULE OUT MYOCARDIAL INFARCT
575	M	69168	99.52	0.389	1.251	98.77	1.23	SIMPLE CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
576	M	24713	99.82	0.773	1.331	98.98	1.02	COMPLEX CARDIOVASCULAR DIS EXC CHF,ISCHEMIC HEART DIS & HYPERTN
591	M	23631	99.57	0.641	1.052	98.41	1.59	NONINFECTIOUS GASTROENTERITIS
592	M	31706	99.70	0.539	1.076	98.65	1.35	ULCERS, GASTRITIS AND ESOPHAGITIS
593	M	10202	99.72	0.587	1.285	98.63	1.37	HEPATOBILIARY DISEASE
594	M	8118	99.57	0.367	1.035	98.83	1.17	HERNIA
595	M	9651	99.49	0.432	1.000	98.75	1.25	HEMORRHOIDS AND OTHER ANAL-RECTAL DISEASES
596	M	6914	99.74	0.720	1.400	98.93	1.07	OTHER COMPLEX GASTROINTESTINAL DISEASES
597	M	107735	99.63	0.557	1.013	98.64	1.36	OTHER SIMPLE GASTROINTESTINAL DISEASES
611	M	15606	99.99	1.990	1.063	99.70	0.30	MAJOR SIGNS, SYMPTOMS AND FINDINGS
621	M	44141	99.52	0.418	0.940	99.36	0.64	BACK DISORDERS
622	M	28692	99.43	0.404	1.002	99.32	0.68	COMPLEX MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
623	M	131709	99.72	0.336	0.875	99.08	0.92	SIMPLE MUSCULOSKELETAL DISEASES EXCEPT BACK DISORDERS
631	M	8470	99.92	0.223	0.800	99.89	0.11	DISEASE OF NAILS

APG Num	Type	Count Included	Percnt Incl.	Weight	CV	Percnt Direct	Percnt Pack.	APG Description
632	M	11545	99.04	0.391	0.992	99.63	0.37	CHRONIC SKIN ULCER
633	M	18435	99.62	0.433	0.927	99.20	0.80	CELLULITIS, IMPETIGO AND LYMPHANGITIS
634	M	6581	99.61	0.253	0.904	99.32	0.68	BREAST DISEASES
635	M	59697	99.69	0.305	0.862	99.48	0.52	SKIN DISEASES
651	M	61587	99.57	0.304	0.949	98.28	1.72	DIABETES
652	M	9894	99.58	0.827	1.106	98.80	1.20	COMPLEX ENDOCRINE,NUTRIT & METABOLIC DIS EXC DIABETES & OBESITY
653	M	21105	99.64	0.237	0.845	98.12	1.88	SIMPLE ENDOCRINE, NUTRITIONAL & METABLIC DISEASE EXC DIABETES
654	M	9325	99.91	1.121	1.150	98.73	1.27	FLUID AND ELECTROLYTE DISORDERS
661	M	42328	99.70	0.498	0.945	98.47	1.53	URINARY TRACT INFECTION
662	M	7734	99.82	0.564	1.250	98.84	1.16	RENAL FAILURE
663	M	31553	99.69	0.549	0.964	99.05	0.95	COMPLEX URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
664	M	19388	99.62	0.412	1.004	99.31	0.69	SIMPLE URINARY DIS EXC URINARY TRACT INFECTN & RENAL FAILURE
671	M	9720	99.41	0.223	1.084	98.27	1.73	BENIGN PROSTATIC HYPERTROPHY
672	M	7691	99.56	0.317	0.974	98.78	1.22	MALE REPRODUCTIVE DISEASES EXCEPT BENIGN PROSTATIC HYPERTROPHY
681	M	14947	99.75	0.343	0.928	99.02	0.98	GYNECOLOGIC DISEASES
691	M	1965	99.85	0.488	0.947	98.90	1.10	HIV INFECTION
692	M	16127	99.99	1.175	1.201	99.26	0.74	ANEMIA
693	M	5475	99.91	1.562	1.923	99.54	0.46	OTHER COMPLEX IMMUNOLOGIC AND HEMATOLOGIC DISEASE
694	M	11263	99.37	0.542	1.636	98.83	1.17	OTHER SIMPLE IMMUNOLOGIC AND HEMATOLOGIC DISEASE
701	M	4212	99.29	0.304	1.018	98.53	1.47	ADULT MEDICAL EXAMINATION
702	M	3	100.00	0.342	1.157	100.00	0.00	WELL CHILD CARE
703	M	214	99.07	0.245	0.761	99.52	0.48	CONTRACEPTION AND PROCREATIVE MANAGEMENT
704	M	43362	99.42	0.214	0.950	99.59	0.41	AFTERCARE
705	M	102226	99.26	0.502	1.239	98.89	1.11	NONSPECIFIC SIGNS & SYMPTOMS & OTH CONTACTS W HEALTH SVCS
721	M	1356	99.93	0.976	1.286	99.71	0.29	UNKNOWN CAUSE OF MORTALITY.

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APPENDIX N

Statistical Measures

Let

C(i,h) = cost of *ith* patient in hospital h

P(i,h) = APG payment for *ith* patient in hospital h

P = average payment across all patients

C = average cost across all patients

N = total number of patients

R^2 is computed as

$$R^2 = \frac{\left[\sum_{i,h}(P(i,h)-P)(C(i,h)-C)\right]^2}{\sum_{i,h}(P(i,h)-P)^2\sum_{i,h}(C(i,h)-C)^2}$$

The Mean Absolute Difference (MAD) is computed as

$$MAD = \frac{\sum_{i,h}|P(i,h)-C(i,h)|}{N}$$

The normalized Mean Absolute Difference is computed as

$$\text{Normalized MAD} = \frac{\text{MAD}}{\sum_{i,h} C(i,h)/N} \text{x}100$$

The Mean Percent Absolute Difference (PMAD) is computed as

$$\text{MAPD} = \frac{\sum_{i,h}\left|\frac{P(i,h)-C(i,h)}{C(i,h)}\right|}{N} \text{x } 100$$

The APG Payment Difference (PD) for hospital h for APG payment model m is computed as

$$\text{PD}(h,m) = \frac{\sum_i P(i,h,m) - \sum_i P(i,h,6)}{\sum_i P(i,h,6)} \text{x}100$$

where

PD(h,m) = Payment difference between APG payment model m and APG payment model 6 expressed as a percentage of payment under APG payment model 6.

P(i,h,m) =Payment for *ith* patient in hospital h under APG payment model m.

APPENDIX O

APG Impact Simulation

Define three subsets of APGs

s = subset of significant procedure APGs

m = subset of medical APGs

a = subset of ancillary APGs

Let

g= APG
i = patient
h = hospital

I(g) = packaging indicator: 0 = packaged, 1 = not packaged

C(g) = interventional radiology consolidation indicator: 0 = consolidated, 1 = not consolidated

W(g) = payment weight for APG g

D = discounting factor for significant procedures

1.0 for highest W(g)

0.5 for all other W(g)

A = discounting factor for ancillary procedures in same APG

1.0 for first occurance of APG

0.8 for all other occurances of APG

B = Multipier to convert payment weights to dollars for base payments

Q(g) = outlier payment threshold for APG g

P(i) = payment for *ith* patient

C(i) = cost or charge of *ith* patient

Y(h) = wage rate adjustment factor for hospital h

Z = fraction of hospital charge or cost associated with wages

X (h) = wage rate adjustment factor applicable to total charge or cost

where X(h) = ZY(h) + 1 -Z

F = fraction of total payment associated with inlier payment

For significant procedures

P(i) = inlier payment + outlier payment

$$\text{Inlier Payment} = \sum_{g \in s} BW(g)X(h)C(g)D + \sum_{g \in a} BW(g)X(h)I(g)A$$

$$\text{Outlier Payment} = C(i) - \left(\sum_{g \in s} Q(g)X(h)C(g)D + \sum_{g \in a} BW(g)X(h)I(g)A \right)$$

where outlier payment included only if > 0

For Medical

P(i) = inlier payment + outlier payment

$$\text{Inlier Payment} = BW(g)X(h) + \sum_{g \in a} BW(g)X(h)I(g)A$$

$$\text{Outlier Payment} = C(i) - \left(Q(g)X(h) + \sum_{g \in a} BW(g)X(h)I(g)A \right)$$

where outlier payment included only if > 0

For Ancillaries only

$$P(i) = \sum_{g \in a} BW(g)X(h)$$

For base payment B should be set such that

$$F\sum_i C(i) = \sum_i P(i)$$

Let

S = subset of patient with a significant procedure

M = subset of medical patients

A = subset of ancillary only patients

$$F\sum_i C(i) = \sum_{i\in S}\left\{\sum_{g\in s} BW(g)X(h)C(g)D + \sum_{g\in a} BW(g)X(h)I(g)A\right\} + \sum_{i\in M}\left\{BW(g)X(h) + \sum_{g\in a} BW(g)X(h)I(g)A\right\} + \sum_{i\in A}\sum_{g\in a} BW(g)X(h)$$

$$B = \frac{F\sum_i C(i)}{\sum_{i\in S}\left\{\sum_{g\in s} W(g)X(h)C(g)D + \sum_{g\in a} W(g)X(h)I(g)A\right\} + \sum_{i\in M}\left\{W(g)X(h) + \sum_{g\in a} W(g)X(h)I(g)A\right\} + \sum_{i\in A}\sum_{g\in a} W(g)X(h)}$$

For outlier payments

$$(1-F)\sum_i C(i) = \sum_{i\in S,M} \text{outlier payments}$$

Let

R(g) = average trimmed charge/cost for APG g where trimming is same trimming used to compute W(g)

SD(g) = standard deviation of trimmed charge/cost for APG g whose trimming is same trimming used to compute W(g)

G = number of standard deviations used to compute outlier threshold

The outlier threshold is computed as R (g) plus a specified number of standard deviations and the outlier threshold is constrained to have a ninimum value.

$$R(g) + G\ \mathrm{SD}(g) = \mathrm{Max}\begin{bmatrix} R(g) + G\ \mathrm{SD}(g) \\ \$1700 \text{ if } g \in s \\ \$350 \text{ if } g \in m \end{bmatrix}$$

The number of standard deviations (i.e., G) above R (g) is selected by solving the following equation.

$$(1-F)\sum_i C(i) = \sum_{i \in S}\left\{C(i) - \left(\sum_{g \in s}(R(g) + G\ SD(g))X(h)C(g)D + \sum_{g \in a} BW(g)X(h)I(g)A\right)\right\}$$

$$+ \sum_{i \in M}\left\{C(i) - \left((R(g) + G\ SD(g))X(h) + \sum_{g \in a} B\ W(g)X(h)I(g)A\right)\right\}$$

where patients included are restricted to those patients for whom the difference between the cost or charges (i.e., C(i)) is greater than the outlier threshold.

The above equation is solved for G using an iterative method.

APPENDIX P

FY 1993 PPS Provider Impact File

This file contains data used to estimate FY 1993 payments under Medicare's prospective payment systems (PPS) for operating and capital expenses. The data are taken from various sources, including the Provider Specific File, the PPS-VI and PPS-VII Minimum Data Sets, and prior impact files. The data set is abstracted from an internal file used for the impact analysis of the changes to PPS published in the September 1, 1992 Federal Register. A description of this file follows.

File Pos.	Format	Title	Description
1-4	9999	Average daily census	From cost reports
6-9	9999	Number of beds	From cost reports
11-15	99999	Medicare discharges	From 1991 MEDPAR file
17-22	9.9999	Case Mix Index	Version 10 GROUPER
24-28	9.999	Oper. Cost of Living Adj.	Applied to providers in Alaska and Hawaii
30-35	9.9999	Capital Cost of Living Adj.	Applied to payments to providers in Alaska and Hawaii
37-42	9.9999	Capital Outlier Percentage	Estimated outlier payments as a percentage of Federal capital DRG payments
44-49	9.9999	Capital cost-to- charge ratio	From Provider Specific File
51-56	9.9999	Disproportionate share (DSH) patient percentage	As determined from cost report and Social Security Administration data
58-63	9.9999	DSH adjustment factor applied to capital payments	Calculated based on DSH patient percentage, post- reclassification
65-70	9.9999	DSH adjustment factor applied to operating payments	Calculated based on DSH patient percentage, post- reclassification
72-76	99999	Hospital's fiscal year ending date	From cost report
78-85	99999.99	Hospital-specific rate	Higher of 1982 or 1987 hospital-specific rates, updated through FY 1993. (Data for Sole Community Hospitals and Medicare-Dependent, Small Rural Hospitals only)
87-90	9999	Post-reclassification metropolitan statistical area (MSA)	As defined by the Executive Office of Management and Budget. (Rural areas designated by two digit SSA State codes)
92-95	9999	Pre-reclassification MSA	MSA where hospital is actually located (see above)
97-102	9.9999	Operating cost-to- charge ratio	From Provider Specific file
104-109	9.9999	Outlier percentage for operating	Estimated percentage of outlier payments as a percentage of Federal DRG payments
111-116	999999	Provider Number	Six character provider number, first two digits identify the State
118-119	99	Provider Type	0 = Short term PPS hospital 1 = Sole community hospital 7 = Rural Referral Center 8 = Indian hospital 11 = Sole community hospital and Rural Referral Center 12 = Alcohol hospital 14 = Medicare- dependent, small rural hospital
121-126	9.9999	Resident-to-ADC ratio	From Provider Specific file, used to calculate the indirect medical education adjustment (IME) for capital payments
128	X	Reclassification status	Indicates hospitals reclassified by the Medicare Geographic Reclassification Review Board N = Not reclassified R = Reclassified for the standardized payment W = Reclassified for the wage index B = Reclassified for the standard payment and the wage index L = Reclassified under Section 1886(d)(8) of the Social Security Act

File Pos.	Format	Title	Description
130-131	99	Post-reclassification region	Used to assign standardized amounts 1 = New England 2 = Middle Atlantic 3 = South Atlantic 4 = East North Central 5 = East South Central 6 = West North Central 7 = West South Central 8 = Mountain 9 = Pacific 40 = Puerto Rico
133-134	99	Pre-reclassification Region	Region in which hospital is located (see Post- reclassification region for key)
136-141	9.9999	Resident-to-bed ratio	Used to determine indirect medical education (IME) factor for operating payments
143-148	9.9999	IME adjustment for capital PPS	Based on resident-to-ADC ratio
150-155	9.9999	IME adjustment for operating	Based on resident-to-bed ratio
157	X	Pre-reclassification urban/rural status	Based on actual location L = Large urban area U = Other urban area R = Rural area
159	X	Post-reclassification urban/rural status	Used to assign standardized amounts (see pre- reclassification urban/rural status for key)
161-168	999.9999	Medicare utilization rate	Medicare days as a percentage of total inpatient days. (Data not available for all hospitals)
170-175	9.9999	Wage index for capital PPS	Used to determine geographic adjustment factor
177-182	9.9999	Wage index for operating PPS	Applied to labor-share of standardized amount

APPENDIX Q

Definition of Hospital Categories

Using these data on provider characteristics from the FY 1993 Payment Impact File, the following hospital categories were defined:

By Geographic Location

LOCATION

Urban Hospitals	Pre-classification urban/rural status = L or O
Large Urban areas	Pre-classification urban/rural status = L
Other Urban areas	Pre-classification urban/rural status = O
Rural Hospitals	Pre-classification urban/rural status = R

BED SIZE URBAN:

<100	Pre-classification urban/rural status = L or O and Number of Beds < 100
100-199	Pre-classification urban/rural status = L or O and Number of Beds => 100 andNumber of Beds < 200
200-299	Pre-classification urban/rural status = L or O and Number of Beds => 200 and Number of Beds < 300
300-499	Pre-classification urban/rural status = L or O and Number of Beds => 300 and Number of Beds < 500
500+	Pre-classification urban/rural status = L or O and Number of Beds => 500

BED SIZE RURAL:

<100	Pre-classification urban/rural status = R and Number of Beds < 100
100-199	Pre-classification urban/rural status = R and Number of Beds => 100 and Number of Beds < 200
200-299	Pre-classification urban/rural status = R and Number of Beds => 200 and Number of Beds < 300
300-499	Pre-classification urban/rural status = R and Number of Beds => 300 and Number of Beds < 500
500+	Pre-classification urban/rural status = R and Number of Beds => 500

URBAN BY CENSUS DIVISION

New England	Pre-classification urban/rural status = L or O and Pre-reclassification region = 1
Middle Atlantic	Pre-classification urban/rural status = L or O and Pre-reclassification region = 2
South Atlantic	Pre-classification urban/rural status = L or O and Pre-reclassification region = 3
East North Central	Pre-classification urban/rural status = L or O and Pre-reclassification region = 4

East South Central	Pre-classification urban/rural status = L or O and Pre-reclassification region = 5
West North Central	Pre-classification urban/rural status = L or O and Pre-reclassification region = 6
West South Central	Pre-classification urban/rural status = L or O and Pre-reclassification region = 7
Mountain	Pre-classification urban/rural status = L or O and Pre-reclassification region = 8
Pacific	Pre-classification urban/rural status = L or O and Pre-reclassification region = 9
Puerto Rico	Pre-classification urban/rural status = L or O and Pre-reclassification region = 10

Rural Hospitals:

New England	Pre-classification urban/rural status = R and Pre-reclassification region = 1
Middle Atlantic	Pre-classification urban/rural status = R and Pre-reclassification region = 2
South Atlantic	Pre-classification urban/rural status = R and Pre-reclassification region = 3
East North Central	Pre-classification urban/rural status = R and Pre-reclassification region = 4
East South Central	Pre-classification urban/rural status = R and Pre-reclassification region = 5
West North Central	Pre-classification urban/rural status = R and Pre-reclassification region = 6
West South Central	Pre-classification urban/rural status = R and Pre-reclassification region = 7
Mountain	Pre-classification urban/rural status = R and Pre-reclassification region = 8
Pacific	Pre-classification urban/rural status = R and Pre-reclassification region = 9
Puerto Rico	Pre-classification urban/rural status = R and Pre-reclassification region = 10

By Payment Categories

PAYMENT LOCATION:

Urban Hospitals	Post-classification urban/rural status = L or O
Large Urban areas	Post-classification urban/rural status = L
Other Urban areas	Post-classification urban/rural status = O
Rural Hospitals	Post-classification urban/rural status = R

TEACHING STATUS:

Non-teaching	Resident-to-bed ratio = 0
Low Ratio	Resident-to-bed ratio <.25
High Ratio	Resident-to-bed ratio =>.25

DISPROPORTIONATE SHARE HOSPITALS (DSH):

NON-*DSH* — DSH adjustment factor applied to operating payments = 0

URBAN DSH BY BED COUNT:

=>*100 Beds*	DSH adjustment factor applied to operating payments > 0 and Post-classification urban/rural status = L or O and Number of Beds > 99
<*100 Beds*	DSH adjustment factor applied to operating payments > 0 and Post-classification urban/rural status = L or O and Number of Beds < 99

RURAL DSH:

Sole Community Hospital (SCH)	DSH adjustment factor applied to operating payments > 0 and Post-classification urban/rural status = R and Provider Type = 1
Rural Referral Centers (RRC)	DSH adjustment factor applied to operating payments > 0 and Post-classification urban/rural status = R and Provider Type = 7 or 11
Other Rural DSH Hospitals:	
	=> *100 Beds* DSH adjustment factor applied to operating payments > 0 and Post-classification urban/rural status = R and Provider Type not equal 1, 7, or 11 and Number of Beds > 99
< *100 Beds*	DSH adjustment factor applied to operating payments > 0 and Post-classification urban/rural status = R and Provider Type not equal 1, 7, or 11 and Number of Beds < 100

URBAN TEACHING AND DSH:

Urban teaching and DSH	DSH adjustment factor applied to operating payments > 0 and Post-classification urban/rural status = L or O and Resident-to-bed ratio > 0

Urban teaching and non-DSH	DSH adjustment factor applied to operating payments = 0 and Post-classification urban/rural status = L or O and Resident-to-bed ratio > 0
Urban non-teaching and DSH	DSH adjustment factor applied to operating payments > 0 and Post-classification urban/rural status = L or O and Resident-to-bed ratio = 0
Urban non-teaching and non-DSH	DSH adjustment factor applied to operating payments = 0 and Post-classification urban/rural status = L or O and Resident-to-bed ratio = 0

RURAL HOSPITAL TYPES:

Non-special Status Hospitals Provider Type = 0

*Rural Referral Center Pro*vider Type = 7

*Sole Community Hospital P*rovider Type = 1

Sole Community Hospital and

*Rural Referral Center*Type = 11 and 7

TYPE OF OWNERSHIP:

Voluntary	Type of Ownership = 1
Proprietary	Type of Ownership = 2
Government	Type of Ownership = 3